The reproduction and negotiation of knowledge in HIV/AIDS consultations in Malawi

by

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I dedicate this work to my father, John Kible Chimbwete, who has not lived to see this phase of my life, yet it is a result of his faith.

Declaration

This thesis is my own work. No part of this thesis has been submitted elsewhere for another degree or other qualification.

Rachel Chimbwete-Phiri.

Abstract

This study investigates the extent to which clients and health professionals in antenatal clinics in a rural hospital in Malawi reproduce and negotiate knowledge about HIV/AIDS during group counselling and educational talks. Malawi is a developing country with economic and public health challenges, particularly in the area of HIV/AIDS. While there have been achievements in getting people tested to check their HIV status, efforts have been hampered by inadequate compliance with HIV/AIDS treatment, especially in the area of prevention of HIV transmission from mother to child.

The study argues that analysis of the discourse of patients and health professionals in antenatal HIV/AIDS consultations can lead to a clearer understanding of different systems of knowledge that have a bearing on outcomes of treatment utilisation and preventive practices. To do this, the study utilises interactional data from healthcare professionals and pregnant women, hospital documents and interviews to assess the extent to which clients are involved in the exploration of knowledge about HIV/AIDS prevention, management, and treatment. The study employs a discourse analytical approach, particulary interactional sociolinguistics which is supplemented by critical discourse analysis.

The study observes that the health professionals use collaborative discourse strategies to increase patient participation during the consultations, such as question and answer exchanges, local knowledge resources such as stories, metaphor, and humour. However, the study also reveals that the interaction is constitutive of power asymmetries reinforced by social and institutional structures which constrain the agency of the pregnant women in the discourse of HIV/AIDS. It observes that there is a tension between medical knowledge and other forms of local knowledge, which are influential yet partially elided from the discourse. The study closes with recommendations for the improvement of actual healthcare practices in order to reinforce client participation.

Abbreviations

ADRA	Adventist Development and Relief Agency
AIDS	Acquired immunodeficiency syndrome
ARIs	Acute respiratory infections
ART	Antiretroviral therapy
ARV	Antiretroviral
AC	Conversational analysis
CADECOM	Catholic Development Commission
CBC	Community based care
CBO	Community Based Organisations
CD4	Cluster of differentiation 4
CDA	Critical discourse analysis
CDI	Community directed interventions
CHAM	Christian Health Association of Malawi
CHBC	Community home-based care groups
CHE	Community Health Educator
DHS	Demographic health survey
EHP	Essential Health Package
EID	Early infant diagnosis
FANC	Focused antenatal care
FBOs	Faith based organizations
GOM	Government of Malawi
GP	General Practitioner
HBC	Home based Care
HIV	Human Immunodeficiency Virus
HSA	Health surveillance assistant
HTC	HIV testing and counselling
HP	Health professional
ICEIDA	Icelandic International Development Agency
IRF	Initiate, respond, feedback
IS	Interactional sociolinguistics
MDHS	Malawi Demographic Health Survey
MI	Motivational Interviewing
MOH	Ministry of Health

MTCT	Mother to child transmission
NAC	National AIDS Commission
NGO	Non-governmental organisation
OPC	Office of the President and Cabinet
OPD	Out patient department
PEP	Post-exposure prophylaxis
PEPFAR	(United States) President's Emergency Plan for AIDS Relief
PHC	Primary health care
PICT	Provider initiated counselling and testing
PLWH	Persons living with HIV
PMTCT	Prevention of mother to child transmission
PSI	Population Services International
SFL	Systemic functional linguistic
SSDI	Support for Service Delivery Integration
STI	Sexually transmitted infections
SWAP	Sector wide approach
TA	Traditional Authority
TB	Tuberculosis
TBAs	Traditional birth attendants
UNAIDS	United Nations Programme on HIV and AIDS
UNC	University of North Carolina
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing
VDC	Village Development Committees
VMC	Voluntary male circumcision
WASH	Water, sanitation and hygiene
WHO	World Health Organization
WVI	World Vision International
YONECO	Youth Net and Counselling Organisation

Chapter 1: Introduction and background to the study

1.1 Introduction

This study investigates and discusses the discursive practices of clients and health professionals in the reproduction and negotiation of knowledge during HIV/AIDS consultations in a rural hospital in Malawi. The study focuses on HIV counselling and education sessions, which are routinely provided to pregnant women before conducting an HIV test. HIV/AIDS is the most challenging health issue in Malawi, followed by lower respiratory infections and malaria (Bowie and Mwase, 2011). The HIV counselling talks are embedded in a context where there are some challenges of inadequate compliance with HIV treatment by some clients, particularly with the recommendations of treatment in the prevention of mother to child transmission (PMTCT) programme. Statistics show that only one third of mothers in the programme adhered adequately to the treatment recommendations. This study focuses on the language and communication of the participants to find ways of partly addressing this problem.

Clients' receipt of HIV counselling and being tested, especially during antenatal care, are some of the key indicators of monitoring progress in the management of HIV/AIDS in Malawi (National Statistical Office, 2014). While researchers in Malawi have examined the problem of lack of adherence to HIV/AIDS treatment by utilising survey data and interviews to address reasons for not adhering to treatment, no research was found that investigated communication in the counselling sessions. Hence this study investigates language and communication in counselling sessions in line with previous research, which has shown that the nature of communication between health providers and clients influences patients' compliance with treatment (Davis and Fallowfield, 1991a) and particularly in the area of HIV/AIDS where poor communication is indicated as one of the factors that have negative effects on compliance with antiretroviral therapy (ART) medication in sub-Saharan Africa (de Kok et al., 2012; Penn et al., 2011; Watermeyer and Penn, 2012). Medical communication is currently enjoying a surge of interest from scholars and practitioners but Malawi and Africa more generally remain largely under-researched geographical areas. This study argues that employing applied linguistics approaches in order to closely examine the

communication between the women and health professionals during HIV/AIDS consultations can partly help to address the problems affecting patient compliance in Malawi. The study employs a discourse analytical approach, mainly using interactional sociolinguistics (IS), while selectively drawing on critical discourse analysis (CDA) and ethnographic approaches.

This chapter will introduce the study by providing the background of Malawi in terms of its health status, its linguistic landscape, the structure of Malawi's healthcare system, the available HIV/AIDS programmes in that system, and health communication interventions pertaining to the pandemic. It will also specify the aims of the study and the rationale behind this project.

1.2 Background of Malawi and health status

Malawi is a developing country with a population of 13,066,320 (Malawi National Statistical Office, 2008). As an economically challenged country it has a number of problems to deal with, and health is one of them. In the wake of HIV/AIDS and persistency of other health related problems, such as malaria, cancer, infant mortality, and maternal deaths, there are many public health and communication activities in disseminating information on preventive measures. HIV adult prevalence was at 10.6% in 2016, and during that year the HIV/AIDS population was estimated at 979,482 (PEPFAR, 2017) which has almost remained the same compared to 10.4% in 2010 (NAC, 2011). Although new HIV infections are significantly prevented over the years due to interventions by different agencies, the statistics remain alarming.

Of interest to this study is the PMTCT programme in antenatal clinics which aims at protecting babies while in the mother's womb to the time they stop breastfeeding, up to 24 months. Counselling and educational talks are held at the women's first visit to the antenatal clinic in order for the pregnant women to make an informed decision to undergo an HIV test. In addition, where mothers were initiated into ART during their pregnancy, there is a need for regular monitoring of their children, even those that are born HIV negative. However, there are some mother and child pairs that are registered but do not return to care – in what is categorised as "loss to follow-up" – and as a result some children remain undiagnosed (Haas et al., 2016). So the PMTCT programme in Malawi is facing problems of inadequacies in treatment adherence, with only about one third of the mothers adhering adequately to the full recommendations of treatment,

especially after delivery (Haas et al., 2016; van Lettow, 2011). Furthermore, about 30% of infant and mother pairs drop out at some point and are put on a "loss to follow-up" list (Haas et al., 2016; Keehn and Karfakis, 2014; Tenthani, 2014) with some health centres having as high as 58% mothers on "loss to follow-up" (Tenthani, 2014: 589). In the district of Zomba, where the health centre is located, a study showed that 18% of qualifying mothers (sample n=387) fully adhered to the programme's recommendations (van Lettow et al., 2011).

Lack of adherence in this instance means, that some HIV infected women drop out of the PMTCT programme six months after giving birth, or sometimes skip visits. In the context of HIV treatment in sub-Saharan Africa, adherence to ART means taking the medication at the right time, with a correct dose, with consistency and storing correctly (de Kok et al., 2012). But PMTCT treatment brings challenges to patients because of strict dosage procedures that are sometimes not easy to follow and require a good understanding of the recommendations (de Kok et al., 2012). In the current study context, just like in most centres in Malawi adherence is measured by patients regularly collecting the medication, i.e. every month, conversely, skipping collection of the drugs is a sign of lack of adherence.

Reasons behind lack of adherence for women in PMTCT include, lack of support from family, economic problems and unequal gender relations that affect their independence (Chinkonde et al., 2009; Haas et al., 2016). Most of these challenges are linked to social-cultural reasons, such as minimum independence in decision making for some women in the largely patriarchal context of Malawi where mothers sometimes rely on others i.e. husbands or clan custodians for decisions pertaining to themselves and children including those concerning health (Jonasi, 2007; Mbweza et al., 2008; Ministry of Health, 2009). Some women do not fully follow the PMTCT medical recommendations while some avoid being tested because of fear of their husband's reaction upon being diagnosed HIV positive (Mbweza et al., 2008; Tenthani et al., 2014). Additionally, lack of male involvement (such as no partners being present in the consultations) is cited as one of the reasons that women fail to adhere to the treatment as some fear disclosing their HIV status to their husbands (Keehn and Karfakis, 2014).

Other researchers in Malawi have cited factors that touch on communication, i.e. that sometimes the PMTCT services may be challenged by an uncaring attitude of some health providers to the mothers (Chinkonde et al., 2009). Some studies have also shown

that there are sometimes asymmetrical power relationships, as providers act patronisingly and paternalistically towards patients, thereby inhibiting the patients from asking questions or seeking clarification about treatment (Evans and Ndirangu, 2009; Kawale et al., 2014, Keehn and Karfakis 2014). While some indicated information gaps, as some women felt they were healthy and did not need treatment (Haas et al., 2016; Kim et al., 2016), others did not understand the ART and feared its side effects (Zhou, 2016). These problems give rise to the need to utilise applied linguistics approaches for a closer examination of the communication that takes place at the health centre between the women and healthcare providers. Provider communication is said to influence patients' compliance with treatment procedures (Gilroy et al., 2004).

Malawi has had to face these health problems while struggling with a poor economy, detrimental cultural practices, and illiteracy levels for about 30% of Malawians aged 15 and above. The literacy rate for men is 76% while that of females is 54% (National Statistical Office, 2008). In this case, the measure of literacy is based on the ability to read and write. Hence, health communication programmes in Malawi strive to involve community members in an effort to eliminate and reduce health problems in an environment where illiteracy challenges a significant number of the citizens. In order to present a bigger picture of the country's background, the social stratification of Malawi is now briefly described in section 1.3.

1.3 Social stratification of Malawi

Malawi is divided into three regions, North, Central and South. The regions are further demarcated into 28 districts which are headed by district commissioners, followed by further sections of traditional authorities within the districts, villages and communities within the villages. These demarcations are presented in Figures 1.1 and 1.2.

Figure 1.1: Map of Malawi showing regional demarcations

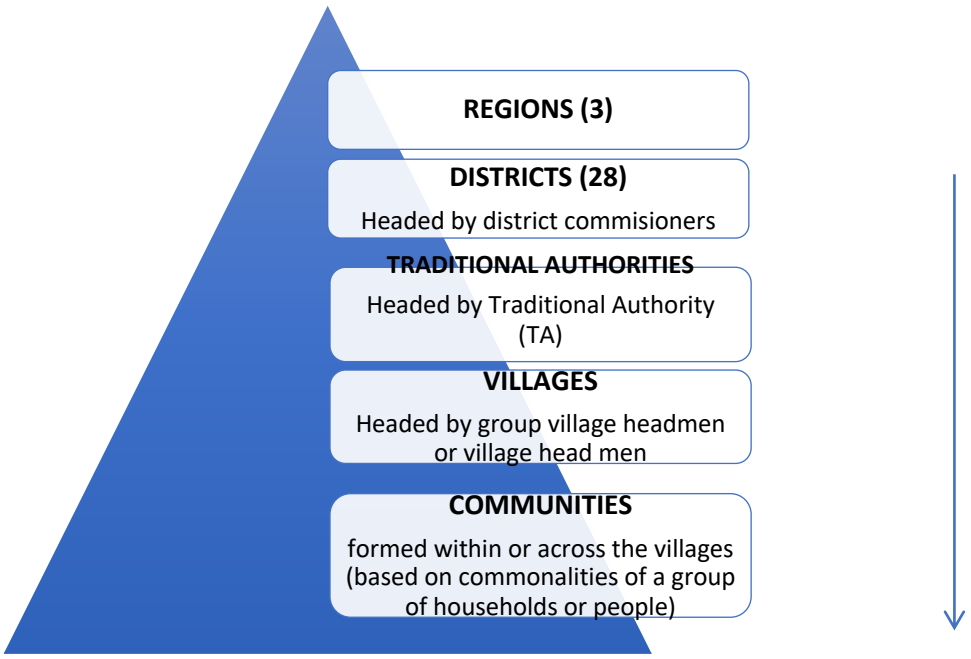


Figure 1.2: Stratification of land in Malawi

Malawi has four cities Blantyre, Zomba, Lilongwe (capital city) and Mzuzu, which comprise the urban area, plus the districts centres which are also considered urban. The rest of the land is defined as rural. About 84% of Malawians live in rural areas (National Statistical Office, 2010).

Malawi depends on agriculture for its income and faces serious economic challenges. Malawi's GDP per capita as of 2015 was at 272.16 USD with the human development index valued at 0.445 (UNDP, 2015). This status is one of the lowest in the human development category, positioned at 173 out of 188 countries. Malawi's current inflation rate, month to month is 5.4%, overall it is one of the highest in the third world region, rated at 22.1%, (Chirambo, 2016; NSO, 2016).

Current problems in Malawi include food insecurity because of lack of drought resistant crops, modern farming equipment and irrigation equipment. The country also has low infrastructural development. The energy sector is performing poorly with only 9.8% of the population using electricity, while there is low energy generation leading to massive power outages (NSO, 2010). In addition, the health sector, especially at the community level, is mainly affected by the economy. According to UNICEF (2015) life expectancy at birth has improved over the years, from being in the 40s in the 1990s to 62.8 in 2014. Despite such improvements, malaria and HIV remain top health challenges as

Malawians mostly experience shortages of drugs in the public hospitals (Khunga, 2015; Malikwa, 2015) and continue to face new HIV infections.

1.3.1 Cultural practices

Malawi has about 15 ethnic groups which have customs (for example marriage or rites of passage for adolescents) that are unique to some ethnic groups, while some customs are shared by several ethnic groups. For instance societies can either be patrilineal, in which a woman lives in a husband's village and the family is considered to belong to the father's side, or matrilineal where a man lives in a wife's village and the family belongs to the mother's side. There are also some societies that practice polygamy. Some ethnic groups in Malawi hold some cultural practices that have over time been condemned for fuelling HIV/AIDS and other sexually transmitted infections (STIs). Among some ethnic groups of the Northern region (see Figure 1.1), especially among those who practice patrilineal marriages, there is a custom called *kulowa kufa*. This is a practice in which a man can inherit the widow of his deceased brother in order to 'keep' the kinship.

Another practice is called *fisi* (hyena) whereby a man is hired to have sex with particular women. This practice is common among ethnic groups in the Southern Region, especially Senas and Yaos (see Figure 1.1). This man performs this in a custom called "*kusasa fumbi*" (literally translated, removing dust) in which adolescent girls are presented to him for sex as a rite of passage into womanhood (Kamlongera, 2007). Sometimes the "*fisi*" (hyena) performs a duty of sleeping with widows in order to cleanse them of the spirit of death; or he is hired to have sex with wives of men who are believed to be impotent so as to help the family conceive. There have been efforts by Non-Governmental Organisations (NGOs) and Government to curb these practices because they fuel the spread of HIV (Malawi Human Rights Commission, 2006).[1] Although these customs are still practised, there has been considerable change in that they are no longer practised openly as before and some individuals are able to challenge them.

[1] In July, 2016 BBC exposed a man who practised as a "fisi" among Sena tribes and is HIV positive. He was being interviewed by a BBC reporter during which he boasted about numerous adolescents, widows, and barren women with whom he had sex with. Later on, the Malawi Government reacted by issuing a warrant for his arrest; he had to answer charges.

The cultural context, although presented briefly here, is useful in the understanding of the discourse of HIV/AIDS in Malawi and the counselling sessions frequently make reference to such practices. Healthcare communication in Malawi can also be better understood when placed within a linguistic context, as done in the next section.

1.4 Linguistic landscape of Malawi

Malawi has a heterogeneous linguistic landscape, such that linguists in Malawi claim that it is not easy to count the languages because of the dialects that exist within them. Linguistically there are 15 distinct languages and numerous dialects spoken in Malawi (Kayambazinthu, 2003; Kishindo, 2001). Some studies state that there are 12 languages with variations within the languages (Kayambazinthu, 1998). The number of languages could be smaller than 12 because some of the languages considered are simply dialects of a single language (Kishindo 2001; Moyo, 2002).

Within the three regional demarcations in Malawi, (see Figure 1.1) Chitumbuka emerged as a lingua franca for the Northern Region; it is understood and spoken by people of the Northern region who also speak other languages (Kayambazinthu, 2003; Moyo, 2002). Chichewa is predominant in the Central Region. Languages spoken in the Southern region are Chichewa, Chinyanja, Chiyao, Chilomwe and Chisena. Of all these languages, Chichewa is spoken by the majority of people in Malawi, followed by Chiyao and Chitumbuka. Chichewa is also spoken in some parts of the neighbouring countries of Mozambique, Zambia and Zimbabwe (Moto, 1995).

English and Chichewa are the official languages, and Chichewa is the national language. So, the languages that are used for national news and documents are mostly English followed by Chichewa (usually a translation of English documents). English is also the dominant language in print media with Chichewa as the second. The choice of language in all domains is a long time debate; many scholars have lamented over the case of neglecting other languages by forcing people to use only two, i.e. English and Chichewa (Kayambazinthu, 2003; Matiki, 2001, 2009; Moyo, 2002, 2003), and sometimes only English – even when it is not understood by others, such as in courts (Englund, 2004).

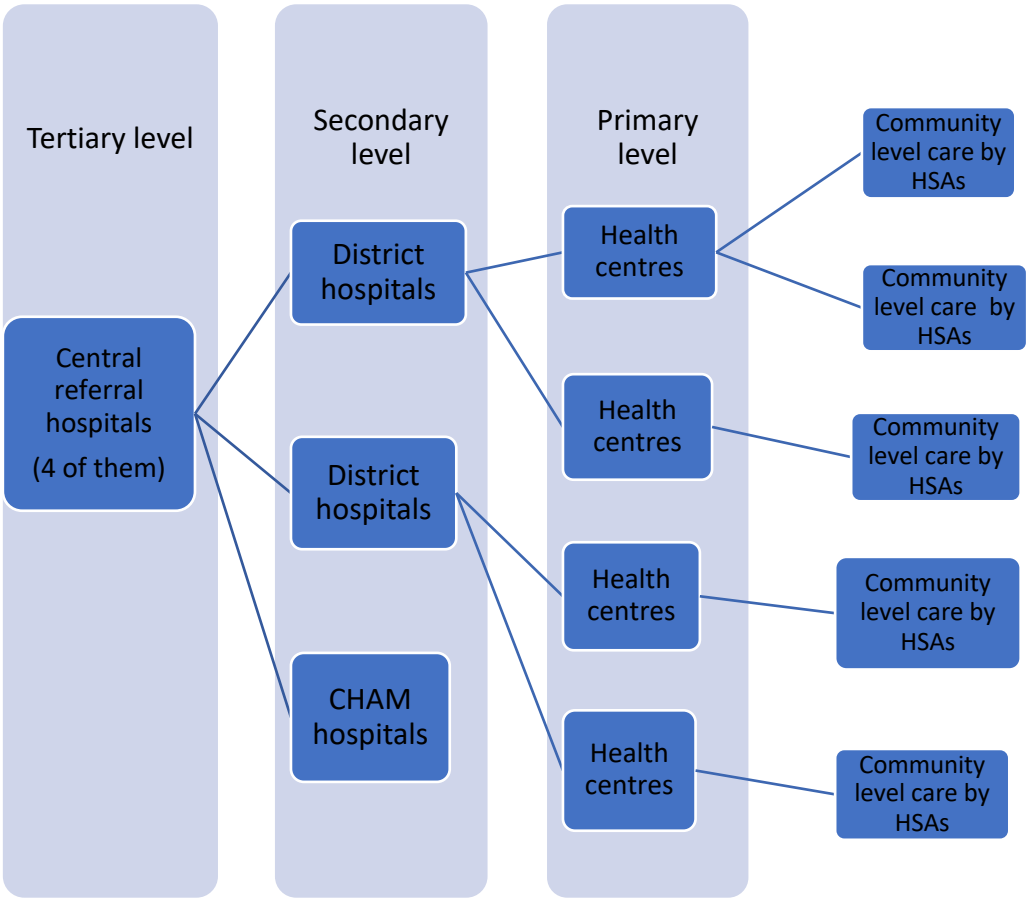
Such a linguistic landscape applies in the health domain as well. The public healthcare system in Malawi predominantly uses Chichewa for patient consultation and among health personnel, whereas English is used for printed communication and by expatriate doctors with the help of interpreters (Kamwendo, 2008b). Chitumbuka is partly used in the Northern region. Most health campaign materials are presented in the two languages, English and Chichewa. Some organisations translate their heath campaign messages for posters, billboards, radio and information leaflets from English to include other languages such as Chitumbuka and Chiyao. The choice of language depends on the targeted location. The study is therefore situated within this linguistic landscape. The study was conducted in the district of Zomba in the Southern Region of Malawi (see Figures 1.1 and 1.2). The language that was used during the data collection to communicate with all participants was Chichewa, as it is the language understood by all participants at the healthcare centre and is the central language used at the healthcare centre.

The next section describes the healthcare system of Malawi in order to contextualise the sessions of HIV counselling and testing conducted in Primary Health Care (PHC).

1.5 General healthcare system

Malawi's public health programme is run by a sector wide approach (SWAP) secretariat in the Ministry of Health. The secretariat coordinates the government's health activities with that of development partners (PEPFAR, 2013). The health service delivery is at three levels (see Figure 1.3). There are tertiary care services by central hospitals (there are four central hospitals for referral cases); secondary care services which are provided by district hospitals, the Christian Health Association of Malawi (CHAM) and by the central hospitals; primary care level is provided by clinics and health centres; and community care is handled by health surveillance assistants (HSAs) with a focus on preventive interventions (Ministry of Health, 2011, 2012; Zere et al., 2007). CHAM hospitals in Malawi are owned by major missions and churches, such as Roman Catholic, Seventh Day Adventist, and Presbyterian Church. CHAM is structurally embedded within the Malawi Governments' SWAP although the hospitals are privately funded. The structure of the healthcare system is represented in Figure 1.3.

Figure 1.3: Structure of Malawi's healthcare system



Malawi implements PHC services through what is called the Essential Health Package (EHP) programme. EHP refers to a prioritised but limited package of basic and cost-effective promotive, preventive, curative and rehabilitative health services determined on the basis of scientific and practical experience in service delivery, and its ability to have a significant impact on the health status of the majority of the people, especially the poor (Makaula et al., 2012; Ministry of Health, 2011). The EHP is delivered at health centres and is free. This package comprises the following health conditions: "vaccine preventable diseases; acute respiratory infections (ARIs); malaria; tuberculosis; STIs including HIV/AIDS; diarrhoeal diseases; schistosomiasis; malnutrition; ear, nose and skin infections; perinatal conditions; and common injuries." (Ministry of Health, 2011: 18)

Despite the package being free, there are serious challenges in that the quality of PHC is largely poor due to funding problems leading to drug shortages and limited health personnel (Bowie and Mwase, 2011; McCoy et al., 2004; Ministry of Health, 2011). The low quality of services and shortage of drugs has left many people in the middle

class and above to rely on private hospitals for health services (McCoy et al., 2004). However, it is noted that the area of HIV and AIDS is handled differently; donor funding agencies keep antiretroviral (ARV) drugs in stock. HIV/AIDS is considered a challenge that requires cooperation of government and donor agencies because ART supplies are not supposed to be interrupted, any interruption in supply can result in serious life threats to the patients who need to take the dose daily and for life (National AIDS Commission, 2011).

The Ministry of Health has an HIV and AIDS unit that coordinates HIV and AIDS services delivery. In collaboration with this unit, National AIDS Commission (NAC) which was established in 2001 is responsible for coordinating all the sectors working in the area of HIV and AIDS, and it reports to the Office of the President and Cabinet (OPC) (National AIDS Commission, 2011; National AIDS Commission, 2009). The National AIDS Commission is governed by a Board of Commissioners whose chairperson is appointed by the President. The rest of the board members are representatives of various constituencies namely, private health providers, public providers, faith based organisations, civil society organizations, youth groups and persons living with HIV (PLWH) (National AIDS Commission, 2011). NAC works down to a community structure, where district AIDS coordinators work with community home-based care groups (CHBC) and faith based organizations (FBOs). The following are some of the funding agencies, *inter alia*, that help in the delivery of health services in HIV and AIDS: Icelandic International Development Agency (ICEIDA), Catholic Development Commission (Cadecom), World Vision International, United Nations Children Fund (UNICEF), University of North Carolina (UNC) project, Dignitas International, United Nations Programme on HIV and AIDS (UNAIDS), United States Agency for International Development (USAID), and United States President's Emergency Plan for AIDS (PEPFAR). A lot more work in HIV/AIDS is done in hospitals and is described in Section 1.6 below.

1.6 HIV and AIDS care in the health centres

There are some major HIV interventions that Malawi government through the Ministry of Health and its different development partners focus on. Recent focus on HIV/AIDS has been on voluntary male circumcision (VMC) (where males are encouraged to get circumcised as a way of reducing chances of contracting STIs) and PMTCT. Older

HIV/AIDS programmes are: individual and couple testing where married or to be married couples are encouraged to go for voluntary counselling and testing (VCT); and provider initiated counselling and testing (PICT) where health providers recommend patients receiving care for other diseases to go for HIV testing.

Malawi adopted an integrated model of care to respond to HIV. The model incorporates HIV treatment, PMTCT, and primary care of other health problems in one clinic. At first there were specified centres where HIV testing and treatment were being conducted. The new integrated approach includes family-care programme model, family planning, ART for all HIV infected patients, mother-infant pair follow-up and other primary care elements for STIs and tuberculosis (TB) in one clinic (PEPFAR, 2013).

Malawi introduced universal coverage of ARTs and provider initiated HIV testing (PICT) with an opt-out model, in 2007; this means that health providers can refer patients, and pregnant women for testing. As of 2016, there were 662,789 patients on ART in the Ministry of Health's HIV treatment programme (PEPFAR, 2017). This represents 86% of all those who are estimated to be in need of the therapy. Healthcare centres and clinics play a major role in promoting health by conducting educational sessions, for instance in antenatal clinics and HIV testing and counselling (HTC) clinics, to encourage healthy lifestyles (Zulliger et al., 2014). However, medical recommendations may not be easily achievable in the context of Malawi, and sub-Saharan Africa in general, whereby patients in rural areas mostly rely on health providers to instruct them and advise them on what to do (Angotti, 2012; Donahue et al., 2012), and health professionals operate in a professional culture of didactic talk and paternalism to patients (Evans and Ndirangu, 2009). In this context, patients are sometimes afraid to ask questions, yet they depend on the health professionals to provide them with health information.

The nature of patient and health professional interaction has an impact on the action taken by the patients regarding treatment (Davis and Fallowfield, 1991). Moreover, the utilisation of HIV/AIDS services largely rests on the kind of reception and interaction the clients have with health information providers, depending on which the process can be encouraging or frustrating to the clients (de Kok et al., 2012; Penn et al., 2011; Watermeyer and Penn, 2012). Thus, the positioning of the client in the healthcare

discourse, their participation in the discourse of HIV and AIDS, and the way health professionals interact with them is examined to understand current practices, which may then eventually feed into considerations of how this might be improved.

1.7 Rationale of the study

Firstly the need to embark on this research was triggered by a drive to understand how people utilise health information amidst the HIV/AIDS promotional messages that saturate Malawian media. Organisations in the health communication sectors, officials in public health and those in the hospitals work hard to disseminate messages on disease prevention and management. But their efforts continue to meet challenges that arise due to, among others, personal, cultural and societal factors. With so many messages constructed about the pandemic, there is "AIDS fatigue"; people have heard much about HIV/AIDS and experienced its effects such that the interest of the general public in HIV/AIDS messages is diminishing and new ways of capturing audiences' attention have to be devised (Mitchell and Smith, 2003; Mitchell et al., 2010: 216). Hence there is a need to examine the current HIV/AIDS discourse practices, in this case at a healthcare centre when participants articulate their knowledge about HIV/AIDS, in order to find ways of filling any existing gaps in the knowledge.

Secondly the study has implications for the practice of healthcare consultations in Malawi and other similar contexts. The literature on Malawi and sub-Saharan Africa has indicated that HIV/AIDS consultations have brought new challenges to health care, when compared to any other health problems. This is so because HIV/AIDS care has introduced a focus on clients' informed consent to be tested and receive treatment and a heightened focus on patients' rights, which is a paradigm shift from a structure of health practitioners giving medical advice and instructions (Evans and Ndirangu, 2009). This paradigm shift extends to the patient: from a passive patient who relied on health practitioners telling him/her what to do, there is a focus on encouraging more engaged patients who have to make decisions concerning their health and self-manage it (Bodenheimer, 2002). Hence there is an increased emphasis on patient centredness in HIV/AIDS consultations, compared to what was in general health care before. Thus, the analysis of data is useful to reveal the discourse strategies that participants use that have an impact on improved healthcare communication.

Thirdly the study contributes to the body of literature in the applied linguistics analysis of healthcare communication by presenting data from an under-researched context of Malawi. The study makes a theoretical contribution to applied linguistics particularly by illustrating how interactional sociolinguistics enables a detailed analysis of interaction to examine the complex connection between talk and social and institutional context from a distinct setting such as that of Malawi. As mentioned at the opening of this chapter, there is a dearth of literature in applied linguistics on health care in Malawi. One study in applied linguistics that focuses on healthcare discourse utilises observations of interaction between expatriate doctors and patients to focus particularly on the choice of language (Kamwendo, 2008b). Another study focuses on HIV discourse at the level of media messages and the data is from interviews, documents, and focus group discussions with audiences (Kunkeyani, 2013). Similarly, very little research has investigated authentic counselling and communication in HIV/AIDS interaction in sub-Saharan Africa, those found are of Kenya (Ndirangu, 2016) and South Africa (Watermeyer and Penn, 2011, Penn et al., 2012). Most of the studies in Malawi have explored the patient perception of HIV testing and counselling in PMTCT, through interviews, surveys and focus group discussions (e.g. Berendes and Rimal, 2011; Hardon et al., 2011; Monjok et al., 2010; van Lettow, 2011) and provider perceptions and experiences (Evans and Ndirangu, 2009).

Currently, no other research was found that examines the discourse of HIV/AIDS consultations in the Malawian context and the impact that communication at the hospital may have on the outcomes, such as adherence to treatment, utilisation of care systems, and on prevention practices. Applied linguistics can offer insights into the nuances of communication that are not easily noticed by studies that have utilised interviews and survey data to understand the reasons for dropping out of HIV clinics and poor utilisation of health care. Analysing healthcare communication is vital in strengthening the use of evidence-based communication practices, which is vital for strengthening patient-centred medicine (Brown et al., 2006). Just as there is need for evidence-based medicine for effective medical practice, there is also need for evidence-based communication (Brown et al., 2006).

Therefore, this study is informative for Malawi's health sector and other contexts with similar characteristics in three ways: for health practitioners' training; for health practitioners' practices; and for public health practitioners to reflect on communication strategies between clients and health professionals. The findings of this research might

be utilised in medical training institutions in Malawi and those in similar contexts with a chance to refer to actual evidence of discourse in health care (e.g. Sarangi, 2004), something that is insufficient for Malawi. As an outcome of this thesis, I hope the results will be applied in healthcare practice to strengthen effective healthcare communication between health practitioners and patients and encourage health literacy for healthcare users in Malawi. The main aim and research questions of the study are summarised in the section below.

1.8 Aim of study

The main objective of this thesis is to investigate the discursive practices of clients and health professionals in the reproduction and negotiation of knowledge about HIV/AIDS in the healthcare context in Malawi in order to improve the practice of the counselling sessions. Related questions that the study addresses are:

1. How do participants reproduce and negotiate knowledge about HIV/AIDS in the healthcare context in Malawi?
2. What is the relationship between social and institutional structures and participants' agency in the reproduction and negotiation of knowledge in the healthcare context in Malawi?

The next section presents the structure of the thesis according to the contributions of each chapter to the objectives of the study.

1.9 Structure of the thesis

This thesis has eight chapters. This chapter, Chapter 1, has introduced the study by presenting a background to the study context, the objectives of the research, and the area of focus for the study. The rationale of the study has also been highlighted in this chapter. Chapter 2 presents the argument that is raised by the study while theoretically positioning it in view of previous research and literature on discourse and health discourse in particular. Key concepts used in the study are also explicated in Chapter 2. Chapter 3 describes the data and methodology of the study. Chapters 4, 5 and 6 comprise the analysis of the data and presentation of findings. Chapter 4 establishes the discursive practices of the clinic as a context of knowledge reproduction and what this entails to

the interaction between the clients and health professionals. Chapter 5 analyses the micro details of the talk. It demonstrates how, by using different discourse strategies in interaction, the participants negotiate their knowledge. Chapter 6 analyses the micro details of the talk in relation to the social-cultural context. Techniques of critical discourse analysis are also selectively utilized in this chapter to interrogate the way in which the interaction is related to the social and institutional structures in which it is embedded and how power relations are negotiated by the participants in the discourse. Chapter 7 discusses and concludes the thesis. It discusses the findings by synthesising the relationship of the major notions of the thesis: power, agency, negotiation and reproduction of knowledge. The theoretical implications of the thesis are also discussed in Chapter 7. The final chapter, Chapter 8, outlines the implications of the study for healthcare practice and highlights the limitations of the study while pointing to areas for further research.

Chapter 2: Theoretical perspectives on healthcare discourse

2.1 Introduction

This chapter reviews literature that informs the current study and explicates the theoretical framework of the study, i.e., interactional sociolinguistics (IS) approach supported by critical discourse analysis (CDA) and ethnographic approaches where relevant. The reviewed literature is presented within the background of healthcare discourse, a conceptualisation of key terms, theoretical approaches that define the analytical framework of the study, and a review of related empirical studies. This study highlights several aspects in relation to discursive practices in health care: knowledge, power, agency, social structures and social practices. Studies in applied linguistics, particularly discourse analysis, have highlighted the importance of paying attention to interaction and social structural context in healthcare settings (Fisher, 1991; Sarangi, 2000, 2010a; Hamilton, 2004; Stivers, 2005). Many more studies have emphasised the role of the social context in healthcare interaction and in HIV/AIDS medical narratives (e.g. Fisher, 1991; Higgins and Norton, 2010; Waitzkin, 1989, 1991). This section will explore some notions that are key to the understanding of healthcare discourse and situate HIV/AIDS counselling practices analysed in this study.

2.2. Health discourse

Scholars have studied the linguistic aspects of health at different levels: at the level of health information in mass media (Hall, 2006; McKay, 2006; Wenham et al., 2009; Aulette-Root, 2010), at the level of health administration (Liu et al., 2014; Waldorff, 2013), at the level of training of medical practitioners (Haith-Cooper and Bradshaw, 2013), and at the level of healthcare delivery (Mishler, 1984; Sarangi, 2007, 2010a, 2010b; Candlin, 2006). By studying health discourse the scholars have illustrated the importance of paying attention to communication in order to achieve effective healthcare delivery (Roberts et al., 2004; Stivers, 2006; Woolf et al., 2005) and utilisation (Berry, 2007; Martin, 2014; Richards and Lussier, 2014).

The discourse of health is understood in the context of the field of health communication. Broadly, health communication research focuses on understanding

communication between health providers, the health providers with their patients, between health researchers and audiences, between leaders of public health and the public, as well as health promoters and their audiences (Wright et al., 2013). Research in health communication has mostly targeted health practitioners where they are reminded of effective communication with clients, and of the need to put the patient at the centre and being informative in their domain (Berry, 2007: 3; Roberts et al., 2004; Woolf, 2005).

This study focuses on the context of healthcare communication with an understanding that healthcare communication is the communication that occurs between health professionals or providers and clients, either at the health centre, in the community or in the home. It is of interest to this study to pay attention to the client's position in healthcare interaction if effective health care is to be achieved. The capacity for knowledge and understanding displayed by a client during healthcare interaction is a sign that empowerment to health has been achieved at various levels of interacting with healthcare information (Finn and Sarangi, 2010). Empowerment in this study context entails "the patient's ability to feel competent to adhere to recommended treatment or prevention measures or to engage in behaviours that may improve health outcomes" which may also include the ability to participate in prevention and treatment decisions and to have informed discussions with healthcare providers (Schiavo, 2007: 59). Thus, in order to investigate both the interaction and relevant social and institutional contexts, discourse analytical methods are used.

2.3 Theoretical framework

This section elucidates the analytical perspective of this study. The study is aware that there are different theoretical perspectives to the approach of discourse within discourse analysis, for instance, regarding the relationship between text and context, and how power is constructed in discourse. There are some who employ a critical perspective with text seen as representing, reproducing and creating social structures (Fairclough and Wodak, 1997, Wodak, 2009), and others who consider the text as a discursive notion with "interpretive potential" while pointing to social structures as a background (Kroger and Wood, 2000; Gumperz, 2001; Cameron, 2001); Sarangi, 2004; Candlin et al, 2017: 131). The study mainly employs IS which provides a detailed analysis of the talk by examining how participants are engaged in interaction, in addition, techniques

from CDA are selectively drawn upon in the analysis to explicate the complex connection between social and institutional structures, and the text.

2.3.1 Interactional sociolinguistics

Interactional sociolinguistics (IS) is an approach to discourse analysis that provides a basis for understanding how people make meaning during interaction. It considers the way society and forces of interaction merge in conversations (Copland and Creese, 2015). IS analytical approaches have been applied more in studies of institutional talk because they aid the understanding of discursive practices, for instance, "how professions are constituted and relations of power are fashioned out of talk at work" (Sarangi and Roberts, 1999: 2). The approach is attributed to John Gumperz who used it as a way of analysing naturally occurring interactions. It is a form of conversational analysis (CA) that considers contextual factors as opposed to interpreting utterances in isolation (Coffin et al., 2010). In this theory, the context and contextual background of interlocutors is important for observers to understand how these affect the interpretation of cues in the conversation. Sarangi and Roberts (1999) have described IS theory as a bridge builder between the macro and micro elements of talk; where the contextual knowledge is linked to the interpretive process in conversational analysis. Such that CA and ethnographic approaches are central to IS.

As an analytical theory, IS postulates that interpretations or meanings are conjointly negotiated between interlocutors (Gumperz, 1982). Interlocutors are guided by interpretive forms which are revised during the interaction. It is not enough to analyse a single utterance, rather, several utterances of the speakers can present a better interpretation of the social phenomenon being observed, and these can also be enriched with direct interviews of the interlocutors or other participants in the context (Gumperz, 1982).

Interaction is central to IS in that whatever people do during interaction enacts the contexts, identities and meanings. The construction of knowledge or meaning making process itself is a negotiation through linguistic signalling processes (Gumperz, 2001). In discourse, participants negotiate understanding about the nature of discourse taking place and its constraints, and such negotiations vary from interaction to interaction (Drew and Heritage, 1992). IS theory is interested in how the speaker signals meaning and how the hearers interpret it because social background and shared knowledge is

'implicated' in the process of interaction (Cameron, 2001). The analysis of language features, according to interlocutors' contextual background, is applicable in analysing healthcare interaction because it presumes different frames of knowledge that participants may have. The negotiation process of meaning making may not be easy to grasp but by allowing the use of detail and feature of talk to be meaningful, IS theory presents a wider application. Paradoxically, the use of detail in a speech for analysis may be too exaggerated. It presents a risk of making false conclusions in some cases but this can be checked by relating to context and background which will be sourced from the other types of data, for example, interviews, and contextual information from documents and observations.

Studies that have used IS approaches or CA and ethnography, employ a more open view of the relationship between the micro and macro level of discourse. Most of them are against making assumptions on effects of social structures or power asymmetries. A number of studies that analysed healthcare discourse have tended to broadly refer to a discourse analytical approach to study interaction (e.g Sarangi, 2013; Sarangi and Gilstad, 2014) without specifying the discourse analysis approach. While others have tended to refer to CA and ethnography to study interaction (Clark and Mishler, 1992; Stivers, T. 2005; Vickers et al., 2012). All these studies, however, show how various situations are negotiated, enacted and are dependent on the interaction as typically done in IS (by combining CA and ethnographic approaches), without making assumptions on power and social relations of the participants.

One such study is by Hamilton (2004) who employs IS methods and argues against viewing medical discourse as tied to institutional constraints and power relations of participants. She shows how IS enables a more specific interpretation of what happens in physician and patient talk. She identifies differences that may shape the medical discourse for example, "the indication of the underlying physical problem" (Hamilton, 2004: 62). She suggests that discourse is shaped depending on the evidence that each participants brings: subjective symptoms leading to more interactive sessions as the patient explains and answers questions; or presentation of objective results by physicians leading to a unilateral presentation. Hamilton (2004) encourages discourse analysts to be open to differences and similarities in ways that can have implications on communication practice.

Other scholars have focused on elements such as roles, identities or knowledge which are relevant in medical discourse as discursive constructs. Zayts and Schnurr (2011) in their study of identities in genetic counselling in Hong Kong, for example, look at identity as something that is not simply a reflection of roles and responsibilities of the interactants in medical encounters but that which is negotiated in discourse. Such that, roles and identities of health practitioners are said to be dynamic and are negotiated in interaction (also Roberts and Sarangi, 1999; Bucholtz and Hall, 2005). Similarly, Zayts and Schnurr (2013) avoided making cultural generalisations about directiveness of healthcare providers in prenatal screening for Down Syndrome in Hong Kong. But by examining micro level of interaction and "relational work" they showed how directiveness is enacted and negotiated in the talk without ignoring the impact of the macro context.

Another study analysed interactions of midwives and pregnant women in obstetric ultrasound scans in South African hospital to show the importance of both professional expertise and communicative expertise (Sarangi and Gilstad, 2014). They demonstrate how communicative expertise of the midwives is interactionally done as they negotiate institutional and professional requirements as well as relational ones. Tannen and Wallat (2006) illustrate the interaction of expert and local knowledge when they analyse talk in paediatric interaction in a North American context. Their study partly describes how knowledge is attained by the client and shared by the practitioner. They suggest that although knowledge between patients and health practitioners constitutes a burden in health interaction there is a negotiation, for instance, when patients ask many questions for clarity.

Clark and Mishler (1992) conducted a discourse analysis of patients' stories in medical encounters to understand how that activity is accomplished in medical encounters. They demonstrate that social relations in clinical tasks are only realised in discourse; sometimes authority shifts, hence avoiding making assumptions about health practitioners' dominance. Other studies have shown that it is not only about advocating for patients' voice in medical encounter (as done by discourse analysts, e.g. Mishler, 1984) but showing how patients participate is important (Stivers, 2005). Stivers (2005) problematizes patient participation when she demonstrates that sometimes as patients participate in decision making of treatment, in parent-paediatrician encounters for example, there are constraints on health practitioners. Particularly, she shows how a paediatrician is led to an inappropriate prescription of antibiotics, for example. In a

related study of narrative co-construction in medical encounters (Vickers et al., 2012) it was found that there were differentials in health provider and patient alignment depending on patients' agency and provider's control. Such differences influenced differences in diagnoses and treatment.

Discourse analysts of medical interaction have emphasised the importance of paying attention to the micro details of interaction. They show how with interactional data varieties of medical interaction are known, for example, in a study by Roberts et al. (2004) where varieties of self-reporting by patients during consultations are revealed and they suggest how such as study could help doctors to tune to individual needs. Thus, their study has implications for achieving patient-centeredness. Perakyla and Silverman (1991) combined ethnographic approaches and CA to the study of HIV/AIDS counselling which allowed them to focus on the local organisation of the talk rather than a general description of the structure of the counselling. In addition, Waynard and Heritage (2005) have shown the importance of analysing interaction in medical encounters because it allows a systematic approach that shows how each interlocutor participates in the discourse, rather than generalising from coding and anecdotes.

An IS approach is therefore useful in analysing the theme of reproduction and negotiation of knowledge that forms the basis of this study. In this regard, IS's consideration of the progression of talk, how it develops, how each participant contributes to the discourse, is crucial for the analysis of the data in this study. IS methods are applied by categorising the functions that utterances in counselling interactions perform and understanding various linguistic devices to interpret the participants' discursive practices in the talk. However, the analytical themes revealed by IS are supplemented by a CDA approach whereby the relationship between talk and the institutional and social structures are critically analysed (see also Slade et al., 2008). Although IS also enables the analysis of contextual aspects of talk, for this study, I found that more studies in CDA make a critical analysis of social and institutional structures, their reproduction, and negotiation in texts than those that were found in IS (e.g. van Leeweun, 2008; Fairclough, 2010; Slade et al, 2008; Wodak, 1997); hence CDA was selectively used in relevant cases. Although CDA can also engage in the details of the talk, for this study, CDA is used to enable the explication of the relationship between the talk and the broader institutional and social context in which the counselling sessions are embedded. The CDA approach and how it is utilized to support IS is set out further in Section 2.3.2.

2.3.2 Supplementing IS by CDA approaches

Most studies of institutional discourse have tended to use IS on its own (e.g. Candlin, 2006; Heath, 1992; Maynard, 1992; Hamilton, 2004; Sarangi and Brookes-Howell, 2006; Zayts et al., 2013; Sarangi, 2013) or just CDA (e.g. Ashcroft, 2015; Aulette-Root, 2010; Haith-Cooper and Bradshaw, 2013; McIntyre et al., 2012; Waldorf, 2013). However, in this study it is believed that supplementing the IS approaches to data analysis with CDA enhances the analysis when addressing the notion of power assymetries and related social and institutional structures. In Chapter 6 of the analysis I selectively refer to studies which adopt a CDA approach in order to frame the critiques that I make of the nature of institutional context in which the interactions take place (Fairclough and Wodak, 2010; van Leeuwen, 2008, 2009). This is so because CDA enables a critical approach towards analysing how participants reproduce or reinforce relations of power in the reproduction and negotiation of knowledge.

Critical discourse analysis (CDA) is a theory concerned with social structures, power relations and how these are manifested in language; and how the social structures and relations of power are, in turn, affected by language. It is defined as the "analysis of different public events that explores the relationship between language and power and the ways in which language is being used to produce, maintain and reproduce positions of power through discursive means" (Young and Harrison, 2004: 2), such that social relations of dominance and inequality are realised in the text (van Dijk, 1996). CDA attempts to explain any type of interaction by considering social and cultural structural processes such as ideology, power, identity, and social inequality and relating them to the text (Fairclough and Wodak, 2010). In this regard, discourses represent social entities and relations, and they are said to construct or constitute the social entities (Fairclough, 1992, 2003). Thus, there are events such as institutional, organisational, and cultural practices, which shape certain discursive practices and sequentially point to the relationship between language and power.

This study has mostly drawn on Fairclough, Wodak and van Leeuwen's CDA versions of discourse analysis. The term 'critical' shows how relations of power, and ideologies have effects on discourse; and also how discourse enables the construction of power, ideologies, social identities, systems of knowledge and beliefs (Fairclough, 1992; Hall, 2001). Fairclough (2010) emphasises the view that being 'critical' in discourse analysis

means elucidating the deterministic aspects of social structures on discourse or what he refers to as 'naturalised ideologies' which determine orderliness of interactions. So the goal of CDA is "showing how social structures determine properties of discourse, and how discourse in turn determines social structures" (Fairclough, 2010: 30).

This critical approach to discourse is considered to be the central purpose of CDA (Fairclough, 2003, 2010; Fairclough and Wodak, 1997, 2010; van Dijk, 1996) and partly informs the current study. For instance, the health texts are part of a higher order of institutionalised knowledge (Foucault, 1972a), thus, they cannot be fully understood in isolation from their context. In health discourse, dominant ideologies of health held by leading institutions are enacted, while at the same time those ideologies are produced, transmitted and reproduced through the discourse (Fairclough, 2010; Wodak, 1997; Wodak and Meyer, 2009).

Thus, CDA strengthens the study's recognition that healthcare discourse is a social event where a number of inequalities and power relations are manifested. The pedagogic process, by the knower (the health professional) to the learner (the client), is where ideologies about health are established. Ideologies are defined as "representations of aspects of the world which can be shown to contribute to establishing, maintaining and changing social relations of power, domination and exploitation" (Fairclough, 2003: 9). These power relations are very relevant for understanding the discourse of health communication, because of its differentiation of the roles of knowledge producers, recipients and institutional structures. CDA's central idea of power and dominance emanates from some of the earlier work of Michel Foucault (1963, 1972), which provides the basis for understanding knowledge practices in language, for example, that of clinical medicine. He describes how illnesses become institutionalised, in that the disease is defined by certain ways of knowing, for which discourse is central. Thus, the power relations between who says what in the 'clinic' are central to medical discourse. Similarly, the relationship between the social and institutional context and healthcare interaction is part of what this study elucidates; hence, where relevant, it found selected CDA approaches useful, i.e., on explaining reproduction of social and institutional structures (Aulette-Root, 2010; Fairclough, 2010), legitimization and recontextualization of social practices (van Leeuwen, 2008; 2009), and negotiation of social inequalities (Wodak, 1997; Slade et al., 2008; McIntyre et al., 2012). The next section, Section 2.4, conceptualises the notions of knowledge as

understood in the current study before explicating the relationship between power and knowledge .

2.4 Categorising knowledge

Central to this study is the concept of knowledge and how it is constructed through discourse by clients and health professionals in Malawi's healthcare context. The study conceptualises knowledge as the understanding of and familiarity with information, facts, concepts or skills, through experience, association or learning (adapted from *Merriam Webster's Collegiate Dictionary*, 2011; Henriques, 2013). The terms 'knowledge' and 'information' are sometimes used interchangeably in texts. Information refers to "the content of new, true, meaningful and understandable knowledge" (Brier, 2014: 24). Information is a precondition for knowledge, one cannot have knowledge about something without having some information about the issue (Brucks, 1985). For instance, when patients interact with health professionals they may have some prior knowledge of a particular health issue, which helps them to take part in information exchange and interpret any new information they receive (Richards and Lussier, 2014). Information is when facts or events are given a form that can be shared or accessed, while knowledge is a cognitive result of accessing that information. For the current study, knowledge is understood as the interpretation and understanding of information (Thompson and Thompson, 2014) and it is displayed in discourse, either as written or spoken text. On the other hand, information is that which is more concrete and can be given, shared and accessed.

Different scholars have categorised knowledge in general terms and others in relation to healthcare discourse. Philosophers interested in epistemology (the study of knowledge) divide knowledge into three types: personal knowledge which arises out of personal experience; procedural knowledge which concerns learning how to do something; and propositional knowledge which is to do with factual or truth claims (Henriques, 2013). Related to these types of knowledge are what psychologist Anderson (1990) identified as two categories of knowledge: procedural, that which relates to the 'how' of practical tasks; and declarative knowledge which relates to understanding of facts and concepts. Declarative knowledge involves constructing meaning rather than just following procedures (Thompson and Thompson, 2014).

In his exploration of knowledge and power from the perspective of CDA, van Dijk (2002, 2003a, 2003b) explores knowledge interfaces in discourse. He lists different types of knowledge: social, interpersonal, group, cultural, shared, institutional, professional, specialised, and presupposed knowledge (presupposed knowledge relates to groups). These different types of knowledge are linked to social knowledge – knowledge that is shared by members of a particular group and manifested in interaction (van Dijk, 2002). According to his typology some of the types are related, for instance social knowledge is of different types depending on the participants involved: interpersonal, group (institutional, professional) and common-ground/local knowledge (whole culture/nation). He also raises the notion of presupposed knowledge in interaction, that interactacts can presuppose shared (social) knowledge in groups or interpersonal interaction.

Additionally, Bernstein (1996) distinguishes two basic classes of knowledge "the esoteric" (the unthinkable) and "the mundane" (the thinkable). In terms of order of meanings, the unthinkable is of the higher agencies, and they operate more on the level of abstraction. The unthinkable is in the order of the high level or expert knowledge. Furthermore, Bernstein relates the idea of knowledge to the concept of competence in its various forms (linguistic, cognitive, cultural, and communicative). The esoteric knowledge can be shared during the doctor-patient consultations (Bernstein, 1996) and could relate to medical specialised knowledge. In interaction, the ideologies of medicine are shared, i.e. what are considered as correct practices and how language is used to build a particular 'hegemony of practice'. In the process, the esoteric knowledge of the health professional may create a power distance between themselves as experts and the clients (Turner, 1987).

In healthcare discourse, information is shared by the interlocutors and in the process their knowledge of an issue is demonstrated. Different scholars have used the various categories of knowledge according to specific interpretations in healthcare discourse. Higgins and Norton (2010) have categorised knowledge as local or expert knowledge in the context of health in sub-Saharan Africa and consider this distinction as a challenge for participants in health communication. They view expert (scientific) knowledge as that which is authorised and conveyed by medical experts and define local knowledge as "ways of knowing that people negotiate in their own terms that are typically outside the boundaries of accepted or authoritative paradigms" (Higgins and Norton, 2010: 8). They believe that all forms of local knowledge are derived from lived

experiences that people have. These ideas are related to the ideas of a cultural anthropologist, Geetz (1983), who relates the shaping of ideas and consciousness as derived from the local context, and reflected so much in the everyday context of people's lives. Another form that is related to local knowledge is experiential knowledge – the idea of knowledge which is based on people's experience as they interact with their everyday environment (after Borkman, 1979). Experiential knowledge relates to everyday experiences of the health professionals (e.g. Sarangi, 2010b) or that of the clients (Boardman, 2014).

Several studies in discourse analysis have presented the interaction of knowledge in healthcare discourse. One study looks at genetic counselling as an interaction of systems of knowledge (Sarangi, 2010b). The study identifies several types of knowledge along which medical professionals operate: scientific knowledge, expert, experiential, specialised, and organisational. Expert knowledge encompasses "an in-depth mastery of field of knowledge" and is shared and accessed by clients and patients in various forms (Sarangi, 2010b: 170). MacDonald et al. (2009) also add to the study of the relationship between types of knowledge by using van Dijk's formulations when they analyse medical interaction as a convergence of different forms of knowledge. They demonstrate how in a medical interview there is shared group knowledge of health professionals which meets with common-ground knowledge of patients; while private or personal knowledge of the patient is transformed into interpersonal knowledge with the health professional. Tannen and Wallat (2006) have shown how a mismatch of expert and local knowledge is negotiated in medical talk, with parents/patients asking questions for clarity in paediatrician and parent encounters, for example. Another study (Boardman, 2014) utilised interview data to analyse the negotiation of experiential knowledge for individuals with a spinal muscular atrophy (SMA) and their families on issues of reproduction in the UK. Boardman (2014) asserts how experiential knowledge presents either benefits or difficulties in the decision making process.

On the macro level, the healthcare consultations may be seen to constitute asymmetries of knowledge and power (Waitzkin, 1989), understanding how that knowledge differs, and how participants negotiate such differentials is of interest in a study such as this one. Moreover, some have argued that the nature of knowledge that emerges in medical interaction cannot be systematically outlined because it is not subject to routine; but it can be ambiguous depending on nature of interaction and interpretations (Turner, 1987). From the literature, however, this study recognises that knowledge in the context of

health entails a combination of various knowledge forms, broadly: declarative and procedural knowledge. These two broad types can be in more specific forms, such as medical, technical, local, common-ground, specialised, non-specialised, or experiential knowledge. So, for example, medical knowledge can either be procedural or declarative in form. More exposition of relevant strands of knowledge as presented by the various scholars is done in Chapter 5 (section 5.3.2). The key terms to the understanding of knowledge production, reproduction processes are described in the next section.

2.5 Processes of knowledge reproduction and negotiation

Three concepts relevant to the construction of medical knowledge in this study are negotiation, reproduction and recontextualisation. Negotiation of knowledge has mainly been considered a central concept within IS approaches (Section 2.3.1). Gumperz (1999) explicates the centrality of 'negotiation of meaning' in IS when he describes the goal of IS to be that of showing how participants in "…[speech] exchanges use talk to achieve their communicative goals in real life situations by concentrating on the meaning making processes and the taken for granted background assumptions that underlie the negotiations of shared interpretations" (Gumperz, 1999: 454). The quote implies that interpretations or meanings are conjointly negotiated between interlocutors through linguistic signalling processes (Gumperz, 2001).

To explain the relationship between the reproduction and recontextualisation of knowledge, Bernstein's (1996) conceptualisation of the three concepts of reproduction, production and recontextualisation of knowledge are relevant. According to Bernstein, knowledge is constructed across three sites: the site of production, the site of reproduction and the site of recontextualisation. Just as in pedagogic discourse, the health centre, where knowledge is relayed, is taken as a site of knowledge reproduction (Bernstein, 1996; see also MacDonald, 2002). Bernstein (1996: 52) views recontextualisation as an overarching field with rules that operate between the field of production (creation of knowledge) and the field of reproduction (acquisition). Recontextualisation is a concept of relevance to knowledge and the processes of its production, transmission and reproduction. Recontextualisation is also a concept used in CDA which explains how ideologies, knowledge and social practices are represented in discourse (Fairclough, 2010) and adapted according to different contexts (van Leeuwen, 2008, 2009).

One of the strategies used in reproducing knowledge involves recontextualisation, whereby texts of one site enter another. Using Bernstein's terms, the health professional and the clients in the healthcare encounter, for example, are recontextualisers; neither of these are producers of knowledge but they are involved in the process of transmission of knowledge in its various forms and sources. Although Bernstein's ideas are centred within the field of education, he points out their relevance to an institution of any kind, including medical institutions (Bernstein, 1996). This is therefore applied to the analysis of medical discourse of this health centre, which is one of the sites of knowledge acquisition, transmission or reproduction in the area of HIV/AIDS.

Some studies in healthcare discourse have shown how knowledge from one site is recontextualised in another and mediated by ideological effects. MacDonald (2002) in his study of medical discourse explicates the notion of recontextualisation using discourse analysis. He explores how medical knowledge is reallocated and transformed in medical discourse, i.e. the medical textbook reproduced in the medical interview. In his exposition of the processes he shows how the different sites of knowledge function, from the production level in research articles to the medical text book, while being appropriated by recontextualisation – within the sites which he describes as recontextualising fields (after Bernstein, 1996). Sarangi and Brookes-Howell (2006) also demonstrated the need to consider the lifeworld of the patient by analysing recontextualisation processes of medical knowledge by offering an account of the derivation of written case notes from 'talk-in-interaction' (p. 202). The case notes were viewed as part of the recontextualisation process which shows the professional competencies and organisational procedures in different modes. Their concern is that the process of recontextualisation drops some important elements of the patient's lifeworld, and these are not recorded in the case notes.

Another related concept in this study is intertextuality, which discourse analysts have presented as a specific form of recontextualisation (Fairclough, 2003; also Hodges, 2015: 45; Linell, 2009). Fairclough (2003) relates recontextualisation to intertextuality, where he states that intertextuality is one form of recontextualisation of texts (Fairclough, 2003; also Hodges, 2015: 45). Similarly, Linell (2009) views recontextualisation as taking place at three levels: intratextual (recontextualisation of texts within the same text or discourse), intertextual (recontextualisation of texts from one text or discourse context to another) and interdiscursive (recontextualisation

between genres or activity types, e.g. counselling and an informal conversation between friends). Drescher (2010) analyses intertextuality, particularly what he describes as "intertextual reformulations" of local knowledge, biomedical knowledge and shared knowledge in HIV/AIDS education sessions in Burkina Faso. He utilises IS and Bakhtinian discourse to relate how speakers orient to various forms of knowledge in the education sessions. Medical consultations may involve all the forms of recontextualisation categorised by Linell (2009) but this study focuses on intertextuality as a specific occurrence in the analysed data. Another relevant concept to the processes of knowledge is power. The relationship between knowledge and power in medical interaction is explored in the next section.

2.6 Knowledge and power in healthcare discourse

The study draws on the relationship between power and knowledge in discourse from Fairclough (1992, 2003) who drew substantially upon Foucault's (1972) contribution to the understanding of social theory of discourse by considering the relationship between discourse and power. Fairclough (2003) emphasises that discourse is constitutive of knowledge, which in turn gives rise to potentially asymmetrical relations of power within the discourse. Another scholar links it to the rising of relations within discourse, "Power relations are embedded in our systems of linguistic meaning and social organisation, and are therefore constantly renewed in social interaction" (Yardley, 1997: 7 after Foucault, 1984). Others believe that as knowledge is shared between health professionals and clients, the dominant discourse (the medical scientific discourse) is reproduced and reinforced in the process (Waitzkin, 1989). Various scholars have elucidated power in the discourse of health care at different levels of interactions, between the health practitioners, and between health practitioners with patients. Most of the literature reviewed in this study utilised a general discourse analysis framework without specifying their framework of orientation.

Different studies have shown how power and knowledge of experts and patients are discursively constructed by interlocutors in healthcare encounters. One study observed internal communication among health workers in a metropolitan clinic in Australia, (Liu et al., 2014) by exploring knowledge and power relations in communication among nurses, doctors and pharmacists, particularly the way it is done over medication and observational charts as well as clinical notes. In that discourse, doctors are constructed as more powerful in relation to nurses and pharmacists. Another study argues that in

patient and health practitioner interaction knowledge may be exchanged from both sides at different stages of the interactions, indicating that the interlocutors may discursively alternate their power positions (Ribeiro, 1996). Some scholars conclude that there are differentials in the enactment of power between doctors and nurses, such as in one US study (Fisher, 1991) where nurses (who were female) were observed to pay more attention to female patients' social voices than doctors did. Fisher (1991) attributes this difference to the distinct positions that doctors and nurses hold in the social and institutional arrangements, where nurses (who were all female) were socially closer to female patients. Another study demonstrates how linguistics choices of nurses were oriented towards building an interpersonal relationship with patients compared to that of doctors (Slade et al., 2008).

Another study by Penn et al. (2011) in South Africa brings to light issues of communication between the health professional and patients, which affect people's health seeking behaviour. Penn et al.'s (2011) study included interactional and communication processes in the provision and reception of antiretroviral therapy (ART) services for HIV/AIDS clients in which they noted existing knowledge gaps between healthcare professionals and patients in ART clinics. Attention given to health professional-client interaction is considered to be very important because the patients look up to the health professionals for information. By positioning the health practitioners as owners of health knowledge, the patients accord power to the health professionals, but in the process they may enact a diminishing status and suppress their own active contribution (Heath, 1992).

Power is also studied as that which institutions enact when they dominate in knowledge production and distribution. Some problematized the elevation of knowledge from one source, such as the practices where local knowledge of powerful nations is turned into global knowledge (Canagarajah, 2002); or where institutional voices – 'hegemonic biomedical discourse' (Aulette-Root, 2010: 192) – are presented as dominant in publications of health promotional materials about HIV/AIDS in South Africa. The discourses of the publications reinforce social and institutional structures that favour biomedicine as the authoritative voice while the local and social discourse is sometimes minimal. This is further illuminated in HIV/AIDS discourse in sub-Saharan Africa whereby participants' social knowledge, as well as their expertise as those with living experiences of HIV/AIDS, were disregarded in educational sessions held not only by health experts (Baxen and Breidlid, 2004; Higgins, 2014; Higgins and Norton, 2010;

Watermeyer and Penn; 2012), but also in the discourses of the mass media in Africa and elsewhere (Banda and Oketch, 2011; Wenham et al., 2009). Such a disregard of clients' voices reinforces asymmetries in power relations at the level at which these discourses are constructed (Wenham et al., 2009).

Knowledge of experts and patients alike is vital in healthcare discourse. Although there is a prominence of particular hegemonies in the articulation of different levels of knowledge, where the dominant may suppress other forms of knowledge (Flowerdew, 2008; Flowerdew and Leong, 2010), all participants in healthcare discourse contribute towards the production or reproduction of knowledge (Fairclough, 1992). Participants' knowledge may sometimes be derived from competing paradigms (Higgins and Norton, 2010) but the emergence of such differences and how they are negotiated can be best understood in actual interaction.

The relationship between knowledge and power has been explored widely in healthcare interaction. In medical settings the patient is required to have information about illnesses and make "knowledge-based decisions" because with knowledge one is likely to act and manage his or her health (Finn and Sarangi, 2010). The concept of knowledge about health and treatment is linked to neoliberal rationality of social reform of medicine (Finn and Sarangi, 2010). That patients in medical settings have "the right to decide what to think rather than being told what to think reflects the neoliberal values of modern consumerism" (McIntyre et al., 2012: 37). In neoliberalism consumers are required to be empowered with knowledge, and also aim at empowering themselves with knowledge (McIntyre et al., 2012). Arguably, patients have the right to know (Osborne, 1997) therefore to be empowered consumers. However, others have argued against the emphasis on making the people know and granting them responsibility to choose without considering their social conditions (Beckman, 2013). For example a study on persons living with HIV/AIDS (PLHA) in Tanzania argues for approaches that consider social life as a condition necessary for people to respond 'responsibly' to the biomedical recommendations (Beckman: 2013: 163). Thus, the process of information exchange in order to achieve knowledgeability of clients is vital, for instance, in HIV/AIDS care where the client has to make an informed decision whether to proceed with having an HIV test or not, and to know what to do to prevent or manage HIV/AIDS. Nevertheless, individual's capacity to act upon that knowledge – agency – is another important notion to consider. The notions of knowledge and power are related to this concept of agency in section 2.6.1.

2.6.1 Participants' agency in discourse

Agency and power are closely related terms in this study. Individual agency to act socially is one notion that has been developed by a number of scholars. Van Leeuwen (2009) explains the idea of 'agency' within discourse in his critical exploration of language. He specifies eight elements of social practices: actions, performance modes, social actors, presentation styles, times, spaces, resources and eligibility. He expands the element of social actors into three roles: as agents – 'doers of action'; patients – 'participants to whom actions are done'; and beneficiaries – 'participants who benefit from an action' (van Leeuwen, 2009: 148). Ahearn (2001: 112) defines agency as a "socioculturally mediated capacity to act" while an agent is viewed as "a person engaged in the exercise of power in the sense of the ability to bring about effects and reconstitute the world" (p. 113). Other scholars view agency as the accomplishment of social action (Bucholtz and Hall, 2005: 601).

This study will focus on agency as a discursive construct (Hall, 2001). The participants negotiate power relations and their agency during the medical interaction. The interaction in health care may imply definite roles of social action where the health professional is the agent and the client is the beneficiary or 'patient'. It is not enough to assume that power differences exist, but to observe and define the social actors as participants in social interaction (van Leeuwen, 2009), for example, in healthcare communication. Some accounts have shown that there are dominant ideologies in the discourses; health practitioners are positioned as producers of knowledge, with patients compelled to passively comply (Brown et al., 2006). In that account, the patient is constructed as being less agentive; however, the positioning of agency in discourse cannot be so definite. Just like power (in Foucauldian terms) there may be shifting roles according to discourse, for instance, expertise, knowledgeability, agentivity are all fluid constructs and they are negotiated in interaction (e.g. Gülich, 2003; Moore, 2005). A related example is by Moore (2005) who studied agency in decision making during HIV/AIDS consultations in Sydney, Australia. Her study demonstrates a distribution of agency between doctor and patient according to their roles: with the doctor more involved in components of medical care such as symptoms, tests, results; while the patient was involved in more material aspects such as the appearance of the symptoms. Sometimes both doctors and patients' agentivity is affected as they respond to other voices external to both of them i.e. the institutional regulations (Moore, 2005). Thus, the communicative role of each participant is to be considered in the construction of

knowledge in health care (e.g. van Dijk, 2001) because texts are not produced or reproduced by a single person (Wodak, 2004), but there are various agencies at play.

While one powerful source of medical knowledge for the health professional is research articles, research institutions, and medical school (MacDonald, 2002), the reproduction of the HIV/AIDS knowledge to the client by the healthcare professional may take a different mode from that of other health issues, where the health professional listens, observes and diagnoses (see Foucault's, [1963] notion of diagnosis). The discourse of the pandemic, HIV/AIDS, emerges from the contributions of various participants: the medical professionals, the clients, the general public and the donor agencies (Drescher, 2010; Seidel, 1993). The meaning of the pandemic hinges on various discourses such as medical science, morality, culture, faith, behaviour, and so on, as understood by different groups of people. Because of the distinct contributions that different groups can make to HIV/AIDS discourse, all participants have a role to play in the production, transmission, and reproduction of the knowledge. Within the discourse of HIV/AIDS, various studies have explored different forms of knowledge that have a bearing on preventive and management of the pandemic. The next section reviews the literature that describe the general discourse of HIV/AIDS, which also defines the context of HIV/AIDS consultations.

2.7 HIV/AIDS discourse

The discourse of HIV/AIDS has evolved from the discourse of 'no cure' to 'treatment and hope', from the view of the disease as a fatal one to one which is a chronic condition (Estes, 2014). Different discourses about the pandemic have developed over time, from the time AIDS was first discovered in 1982, mainly as an epidemic in the homosexual community, to the present, when it is understood as a pandemic that may affect everyone (Estes, 2014). As the discourse of the pandemic changes, the discursive practices and the formulation of messages changes, as do people's responses to them. Some studies on HIV/AIDS discourse in sub-Saharan Africa and beyond have shown the contention between biomedical and social knowledge, which in turn affects patients' power and autonomy to act (Higgins and Norton, 2010; Mitchell et al., 2010; Watermeyer and Penn, 2012) .

Patient autonomy and power, when making decisions about health, is very important. Different scholars have studied patient autonomy, patient empowerment in doctor-patient relationships in European, America and Australian contexts (Brown et al., 2006; Gotti and Salager-Meyer, 2006; McIntyre et al., 2012) but, despite the quest for an egalitarian relationship between patients and health practitioners, sometimes socio-economic status changes the power dynamics of interaction in health care (Doherty and Saunders, 2013). In a country where there is usually a gap of knowledge between classes due to challenges in literacy levels and language use (Kachiwanda, 2009; Kamwendo, 2008b) the nature of healthcare communication and its dynamics are considered, especially the positioning of the client during interaction in order to find ways of empowering the client. An empowered individual is "constituted as a rational and responsible agent who can properly (or at least potentially) act on information and 'monitor' themselves" (Finn and Sarangi, 2010: 244-245).

Several studies have described the varied discourses of HIV/AIDS as depicting power and ideologies in favour of the industrialised nations. The discourses are varied, according the context of discussion. These discourses are of, *inter alia*, medical science, development, human rights, racism, local, legal, ethical, cultural nature, literacy, moral, and religion (Banda and Oketch, 2011; Mitchell et al., 2010; Seidel, 1993; Wenham et al., 2009). The dominant medical and Western discourses are said to be controlling and excluding other discourses and they are competing against discourses of rights and empowerment as expressed by some activists' discourses within sub-Saharan African countries, such as South Africa, Botswana, and Uganda.

The notions of ideology and power in HIV/AIDS discourse are illustrated in a study of media from Australian newspapers (Wenham et al., 2009) which showed that AIDS was portrayed in favour of the industrialised nations but undermined the efforts of the nations in sub-Saharan Africa, a region that is mostly affected by the pandemic. The author concludes that industrialised countries were represented as credible sources of knowledge regarding the pandemic, while Africans were under-represented, or where Africans were represented it was done in a critical way. In this regard, the medical discourse is said to "favour the Western medical and scientific knowledge over alternative knowledge and approaches" (Wenham et al., 2009: 290).

Discourses of medicine, as originated from the developed world, are said to be leading, albeit with some contradictory local discourses of Africa (Higgins and Norton, 2010;

Drescher, 2010, Seidel, 1993). These local discourses seem silenced by health promotion and media and are believed to have a drawback on individual management of the pandemic. The discourses that arise in different contexts are to be understood if a meaningful and successful discourse is to be achieved in the institutional context. Other studies identified discourses on HIV/AIDS that are prevalent in sub-Saharan Africa, the ways in which HIV/AIDS is talked about, its place in the discourse, and the ways it acquires different meanings (Drescher, 2010; Seidel, 1993). A study by Seidel (1993) identifies a medico-moral discourse, a Christian intervention that tends to be judgemental to HIV/AIDS victims, as one that is dominant. Drescher (2010) conducted a study in Burkina Faso in which he observed that there was contextualisation of local discourse of HIV/AIDS, where HIV/AIDS is linked to discourses about sexuality and death.

The medico-moral discourse is not very different from the behavioural discourse that is widely promoted by most HIV/AIDS campaigns in sub-Saharan Africa. While the behavioural campaigns promote positive behaviour, the moral discourse may be seen to have a discriminatory effect on those who are affected by the pandemic. Most of these discourses, for example, moral and religious discourses about HIV/AIDS, are competing with the biomedical discourse. Despite all these efforts, HIV/AIDS remains a major health challenge in sub-Saharan Africa (Mitchell et al., 2010; Penn et al., 2011; Watermeyer and Penn, 2012). This study seeks ways of having a meaningful dialogue to curb the pandemic without health communicators being ignored by the audiences.

An understanding of how different participants in the discourse construct their meaning of the pandemic is vital to the development of meaningful HIV/AIDS discourse. A study has shown how choice of words, for example, in describing HIV/AIDS-related experiences reflects people's construction of the meaning of the pandemic and has an effect on certain practices (e.g. fuelling stigma and discrimination towards people living with HIV) (Breitinger, 2011). In Malawi, HIV is commonly referred to as *kachilombo ka HIV* (HIV virus) where *kachilombo* literally means a creature (insect, animal, virus and bacteria are translated by the same term) in Chichewa. It is understood to be a roaming creature that may be found in anybody's blood, where the phrase *amupeza nako* literally translated as 'has been found with it' is understood by many Malawians as referring to HIV, even without mentioning the virus itself. Breitinger (2011) believes that use of *kachilombo* (the virus) may be allegorical and a proverbial figurative speech to refer to HIV as a "tiny monster". He thinks that such a speech has an affective quality

of compassion to the HIV threat and its victims. The major interpretations of Breitinger's study are that AIDS is seen in in Malawi as a disease for the promiscuous, the rich and urban dwellers (2011).

In the related context of South Africa, recognition of the importance of culture and language has been upheld by other research into the dispensing of antiretroviral (ART) medication (Penn et al., 2011). In their research on ART clinics and the interaction that takes place between patients and health workers, Penn et al. (2011), confirmed the existence of language barriers, for example those arising due to difficulties in terminology linked to HIV/AIDS, testing, names of the medication and instructions that were given for taking the medication. They believe that adherence to ART can be improved if cultural, linguistic and contextual factors are taken into consideration. However, despite the various discourses, biomedical discourse has dominated all other discourses. It becomes imperative to understand the construction that participants have of HIV/AIDS amidst the different discourses that have arisen over time. This understanding of power as related to HIV/AIDS discourse provides a strong analytical base for assessing how clients and healthcare professionals position each other in relation to knowledge about HIV/AIDS during interaction. The next section draws from the literature in the Malawian context to appreciate the extent to which knowledge and power in relation to health is represented in that setting.

2.8 Healthcare discourse in the context of Malawi

In order to understand the health discourse in the Malawian setting, its socio-cultural context as it relates to discursive practices of health is explored in this section. There are certain beliefs and attitudes that have repercussions on health seeking behaviour (Martin and Nakayama, 2008). The Ministry of Health in Malawi recognises some cultural challenges in fighting malaria, for instance, the belief that malaria is caused by witchcraft; that some families need to seek permission from older people or community leaders to take a patient (pregnant mothers or when a child is sick) to the clinic; reliance on traditional birth attendants or traditional healers; and that it is culturally inappropriate to share with others knowledge of pregnancy in the early months (Ministry of Health, 2009). The studies presented in this section are not from a discourse analytic perspective but they do offer insights into the general discourse of health in Malawi.

Several studies in Malawi have shown the role of beliefs and community perceptions in seeking health care. For instance, for families to access health, patrilineal and matrilineal marriage traditions may disempower or empower women in their decision making, respectively (Mbweza et al., 2008). Culture may reinforce some practices that may negatively impact on health seeking behaviours. Jonasi (2007) observes that individuals may not have a say concerning their lives and cannot make important decisions about their health, rather, they turn to those who are custodians of wisdom, such as grandmothers, and this has an impact on maternal and child health matters at the household level. In a similar study, Kerr et al. (2013) noted that grandmothers have an influence on young mothers, for instance regarding child feeding practices. Kerr et al. (2013) considered the implications of involvement of grandmothers and their local knowledge for health promotions and health education. Their study concluded that incorporating local knowledge into the medical system is a difficult approach. Perhaps, the two are not easily compatible, and health discourse would rather confine itself to the physical or biological elements rather than considering other contextual factors. However, such contextual factors, more importantly such local knowledge, cannot be ignored in healthcare discourse because they have implications for the adoption of effective health practices.

Cultural challenges are also considered when Dionne and Poulin (2013) explored Malawians' lack of acceptance of male circumcision as a strategy for reduction of HIV infections. Their study showed how attitudes towards circumcision are matched by ethnicity and region of residence in Malawi. Belonging to an ethnic group, a religious group, and having certain perceptions of customs influence people's decisions on health matters.

Other scholars believe that the level of education and the cultural context combine to influence health behaviours (Stephenson et al., 2013). Stephenson et al. (2013) observed that where there are culturally risky factors, education brings in changes in a positive way; education empowers individuals. Empowering women with health literacy is one way of improving family and individual health (Hogg et al., 2005). Prevention of mother to child transmission (PMTCT) is one such case where education and cultural factors become a practical issue. There are still challenges in the use of these services for HIV positive women, and, as mentioned earlier, some women still deliver at home and are attended to by traditional birth attendants (TBAs). One report shows that, as of 2012, attendance by skilled attendants in urban areas was at 84% while in rural areas it

was at 69% (Kumbani et al., 2013). Some women still go for traditional birth attendants because of long distance to health centres and this affects the PMTCT programmes. These socio-cultural issues contribute to the retardation in progress for HIV/AIDS programmes and may present challenges in achieving effective communication in the area of HIV/AIDS. However, the extent to which such practices pose challenges cannot be concluded without understanding the discursive practices of health care in Malawi and the role of each participant in the production of meaningful practices.

This study highlights individual knowledge about HIV/AIDS as an important aspect in the fight against HIV/AIDS in Malawi, where accessing and utilising information about HIV/AIDS can lead to an effective fight against HIV/AIDS (see also National AIDS Commission, 2010.) It is through accessing information that one obtains knowledge. Malawi Government through National AIDS Commission emphasises the need for everyone to have 'comprehensive knowledge' about HIV/AIDS. The National Statistical Office of Malawi (NSO) (2010) defines 'comprehensive knowledge' as

> knowing that condom use and having just one HIV-negative faithful partner can reduce the chances of contracting HIV, (2) knowing that a healthy-looking person can have HIV, and (3) rejecting the two most common misconceptions about HIV transmission—that HIV can be transmitted by mosquito bites and that HIV can be transmitted by supernatural means (NSO, 2010: 186).

The above definition implies the role of information in knowledge. The definition is based on what people need to know, but does not refer to any action derived from what the people know or the application of their knowledge. As such this study uses the understanding of knowledge about HIV/AIDS as the information that people hold about HIV/AIDS and is used to guide their management and preventive practices of the pandemic.

Healthcare providers and community health workers are important sources for dissemination of health information and the most trusted, although other media types are also accessed (Pakachere, 2010; SSDI, 2012, 2013). This dependence that individuals have on the healthcare system as a resource for care as well as for health information entails that healthcare discourse in Malawi requires considerably more attention than is currently the case.

A considerable amount of research has been done on the utilisation and effects of health information in Malawi and reveals how the power and knowledge of interlocutors are manifested in the discourse. One such study is by Donahue et al. (2012) in which they tested mothers' knowledge of mother to child transmission (MTCT) of HIV, early infant diagnosis (EID) and infant ART in Malawi. Their study analyses knowledge of these healthcare users and they show that there is total dependency on healthcare providers to share information. The women had an unquestioning attitude towards healthcare providers as givers of knowledge. These perceptions meant they did not ask questions or seek explanations.

Another study (Kawale et al., 2014) emphasises the vitality of communication of the healthcare provider, when her participants' responses revealed the importance of the provider's authority and opinion in patient's decisions about child bearing. Despite the knowledge gap of patients and discouraging provider attitudes, the patients do not seek further information elsewhere. In Malawi, many patients feel that health workers have an attitude that creates a distance (Ministry of Health, 2009). However, existing studies in Malawi have either focused on the effects of choice of language at a macro level (Kachiwanda, 2009; Kamwendo, 2008a) or have observed the interaction without analysing the discursive strategies of the patient and health professional in healthcare interaction (Donahue et al., 2012; Kawale et al., 2014). This study will therefore consider the discursive practices in the context of HIV/AIDS care.

The focus of the current study is on the information that participants have about HIV/AIDS as central to the reproduction and negotiation of knowledge during healthcare interaction. The literature has attested that clients have knowledge which they bring to the counselling sessions at the hospital (Beckman, 2013). This information and any prior knowledge impact on what is shared during medical consultations and the consequential action; and thus, that prior knowledge held by clients has a bearing on the interaction between the health professionals and the clients. One context that allows an encounter between health practitioners and individuals concerning HIV/AIDS issues is counselling, and forms the bulk of the data for this study. The organisation of HIV/AIDS consultations in Malawi is explained in detail in section 2.8.1.

2.8.1 HIV/AIDS consultations in Malawi

There are many activities around HIV/AIDS at various levels of health in Malawi. HIV/AIDS care is conducted in separate clinics in hospitals; however, the discourse of HIV/AIDS has been diffused in all other departments of health care, in out-patient departments, under-five clinics, and antenatal clinics, among others. Individuals in need of voluntary counselling and testing (VCT) go to HIV testing and counselling (HTC) clinics at the health centre level. Other patients are recommended to go for HIV testing in what is called 'provider initiated counselling and testing' (PICT) according to the symptoms and condition observed by doctors or clinicians.

When diagnosed HIV positive, referrals are made from the HTC clinic to the main clinic, or another clinic close to the client's home for ART. At ART clinics further counselling is conducted in the form of group educational talks during waiting times followed by individual counselling with the clinical officers or health workers when necessary. After giving birth, more follow-ups and in some cases nutritional programmes are provided for HIV positive mothers. This structure reflects the importance that the Malawi government accords to HIV/AIDS clinics. In addition, with the provider initiated counselling model, women are said to have more access to testing and counselling services than men (Mitchell et al., 2010). Although there is a vibrancy of activities, little research has focused on healthcare discourse in this context, yet there are challenges in the reception of care as manifested by individuals' challenges in adherence to medication (Chinkonde et al., 2009; van Lettow et al., 2011; Haas et al., 2016; Flax et al., 2017). Furthermore, some studies in Malawi have pointed to contextual factors that bring challenges to the nature of interaction during counselling. For instance, the Western model of individual rights on disclosure and HIV testing is said to differ from that of the sub-Saharan context like Malawi (e.g. Angotti, 2012); and some women consider HIV testing compulsory and part of routine to access antenatal care (Angotti et al, 2011).

Chapter 3 will show how Malawi includes group counselling, and individual counselling, depending on the number of clients attending the sessions. In this regard, group counselling conducted in this setting may pose challenges in achieving the results that traditional counselling would present in other settings. In general, counselling refers to "a process of enabling individuals to describe their problem, and listening sufficiently well that the helper can grasp the meaning and offer appropriate advice"

(Davis and Fallowfield, 1991b: 24) Apart from listening to the client's problems counselling may involve giving information to enable the client to make an informed choice (Zayts et al., 2012). Traditionally, counselling is meant to be therapeutic for the clients when they are distressed by an experience of some kind. Balmont and Waksberg (2012) present components of therapy as being when the client is provided with a safe relationship, he or she is given a chance to explore an interpretation of his or her experiences, to understand them, and connect them with their inner resources to achieve change or coping strategies. Silverman (1997: 41) analysed HIV counselling discourse and describes it as a type of interaction that 'attempts' to align the counsellor and the patient, as "either the questioner and the answerer, or as speaker and the recipient". The HIV counselling discourse takes an "interview format and information delivery format" (Silverman, 1997: 41). HIV counselling also puts the client at changing 'footings' as the producer and receiver of information (Peräkylä and Silverman, 1991; notion of 'footing' is after Goffman, 1981). However, the group counselling utilised in this context is unique and may not fit within the traditional aims of counselling.

The context of HIV/AIDS counselling in Malawi is an interesting point in understanding how the discourse provides an affordance for all participants to construct meaning. Incorporating various voices in the discourse, and not ignoring them is one way to achieve an effective fight against the pandemic. This study, therefore, investigates how the clients and health professionals, as participants in the HIV/AIDS discourse, reproduce and negotiate their knowledge about HIV/AIDS in the context of HIV/AIDS counselling in Malawi.

2.9 Chapter conclusion

The chapter has explored the theoretical perspective of this study. It has also looked at general literature about healthcare discourse before narrowing it down to the context of HIV/AIDS and Malawi in particular. In addition to meanings of key concepts, as defined by various scholars and how they are used for the study, the literature has shown that knowledge or power is negotiated and also enacted in discourse. Although at the macro level of discourse the power and knowledge of experts may be viewed as deterministic, focusing on the interaction carried out at the micro level may reveal a different dynamic which features some degree of agency on the part of the clients. As shown in this chapter, previous research has looked at discourse practices in health care

for different illness consultations and found that patients and health practitioners discursively construct each other's power positions – both the health practitioner's expertise and authority, and the patient's knowledge (or lack of it) – and that existing power relations and social structures are thereby reproduced in discourse. Hence, this study principally utilises the interpretative approach of IS, while also drawing on certain aspects of CDA and ethnographic approaches, as it examines the discursive practices of clients and health professionals in the reproduction and negotiation of knowledge about HIV/AIDS in the antenatal context of health care in Malawi. Chapter 3 provides a description of the research design for this study.

Chapter 3: Methodology

3.1 Introduction

This chapter presents the methodology by laying out the research aims, research paradigm, research methods, data collection methods, research techniques employed, the data collection instruments, the study's sampling techniques, a description of the study site, study participants, analytical strategies and the theoretical framework for data analysis.

The study uses an interpretive paradigm as it recognises the social construction of knowledge, in which discourse has a role to play. The study is social constructionist in nature because it is a kind of inquiry that requires an involvement of several actors in interaction to see how they understand and provide meaning to the phenomenon (Hennink et al., 2011; Ross and Matthews, 2010) of health. According to Crotty (1998: 42) social constructionism " is the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world…." Social constructionism asserts that reality is socially constructed such that "groups construct knowledge of each other and thus a culture of shared meaning is created" (O'Reilly and Kiyimba, 2015:18). Social constructionism is relevant to this study because of its focus on making meaning of social realities with various participants of the study. Thus, the study provides answers to questions surrounding HIV/AIDS 'to make sense of the meanings others have of the world' derived from the social interactions of people pertaining to the phenomenon (of HIV/AIDS) (Creswell, 2009: 63). This meaning can only be understood and constructed within discourse.

This is an interpretive study which draws on qualitative data involving Malawian health professionals, healthcare clients and an examination of institutional elements, to understand how people perceive HIV/AIDS as a health issue and how to manage it. It was essential to employ qualitative data collection methods because such methods enable the exploration of detail beyond what is provided by statistical data; they provide a possibility of detail regarding social, organisational and individual characteristics, and the attaching of meaning to them (Schensul, 2012). Qualitative research methods have enabled me to obtain an in-depth analysis of the issues surrounding HIV/AIDS, as understood by the health practitioners and the clients at a health centre level. It was also

essential to engage the participants of HIV/AIDS discourse at the healthcare centre in order to hear their interpretations and how they perceive and construct the pandemic.

3.2 Ethnographically informed approach

The study applies some techniques of ethnography alongside discourse analysis within the methodological approach for the current study. The study employed some approaches of ethnography such as conducting informal interviews, observations, and recording of field notes in order to support the IS and CDA approaches (e.g. Roberts et al., 2014; Sarangi, 2010a; Baszanger and Dodier, 2004; Copland and Creese, 2015). The relevance of ethnographic approaches to linguistic studies such as this one is illustrated by Roberts, et al. (2014) who employ a combination of ethnographic approaches and discourse analysis in a study of assessments of clinical skills for general practitioners in England. Their study demonstrates how analysis of interactional data is supported by other ethnographic data sets for the contextualised analysis of the clinical assessments i.e., participating in the administration of the examinations, holding discussions with the participants, recording field notes and collection of documents. Another sociolinguisitic study by Sarangi (2010a) also employs what is described as "ethnographic fieldwork" as one way of obtaining contextual data for the analysis of health care interaction. Similarly, for this study, IS methods are supported by the data obtained using selective ethnographic approaches.

Ethnographic approaches are used where the aim of the researcher is to describe and understand the behaviour of a social or cultural group (Hennink et al., 2011); the researcher may have 'first hand experience' of a setting and of observation methods (Mason, 2002: 55). The 'first hand experience' requires researcher participation in the activities of the group so as to observe the occurrences in a natural uninterrupted setting (Baszanger and Dodier, 2004; Hammersley and Atkinson, 2007; Hennink et al., 2011). Linguists employ ethnography to study how people use language to inform us about wider social structures and ideologies (Copland and Creese, 2015).

Some of the ethnographic approaches were relevant to this study because of the need for close, contextualised empirical observation, and the need to investigate language and related discoursal features as social phenomena – all of which present affordances for the interpretation of wider ideologies operating in the social context. The phenomenon of HIV/AIDS discourse cannot simply be deduced from documents and

readings but requires an investigation that can unfold the social processes (Baszanger and Dodier, 2004) involving the people, institutional practices, and social structures. Ethnographic approaches were selectively drawn upon to support IS where relevant, particularly because it provided the tools to observe the interaction and contextual background and to record the talk in real time within its immediate context. The ethnographic data was later helpful in making sense of other discursive data such as HIV/AIDS hospital guidelines and clinical institutional documents, and in making sense of meaning from transcribed interviews with various participants. Consequently, some elements of the ethnographic approach, which are specified in more detail in Section 3.3, are employed to understand the health centre's activities in the care of HIV/AIDS clients and their relations to the broader social-cultural context in which they take place. The next section describes the data collection process and relevant techniques in more detail.

3.3 Data Collection

The study involved audio recordings of group counselling sessions supplemented by interviews with selected health professionals and clients, examining relevant documents, and observations of activities around HIV/AIDS care at the health centre. Table 3.1 presents an overview of the data set for this study.

Table 3.1: Summary of activities vis-à-vis collected data

Type of data	**No.**	**Remarks**
Audio recordings of PMTCT group counselling sessions	7	Core data
Client interviews	37	Supplementary data
Health professional interviews (3 HTC counsellors, 2 nurses, 1 Expert Client and 1 Medical Assistant)	7	Supplementary data
Observations of activities at the antenatal clinic	various	Supplementary data
Clinic HTC/ART documents	various	Supplementary data

As presented in Table 3.1., the main focus of the analysis is on audio data pertaining to HIV prevention of mother to child transmission (PMTCT) in the antenatal and HTC clinic. These are derived from group counselling and educational talks that are routinely conducted for the PMTCT programme at the antenatal clinic. The analysis was also supplemented by interviews with selected pregnant women attending the group

counselling sessions, HIV counsellors, nurses and a medical assistant in charge of the health centre. Other interactional contexts were also relevant in the analysis of the data such as, general observations of activities pertaining to HIV/AIDS care in the antenatal clinic and relevant hospital documents. A more detailed description of the data collection techniques and the analysed data is set out in sections 3.3.4 and 3.3.5 respectively.

3.3.1 Sampling

This section explains the sampling procedure that was followed. The study mainly used purposive sampling for all the participating groups. It should be mentioned here that for purposes of protecting the privacy of participants, pseudonyms are used for names of participants and the health centre in this thesis. In all cases codes have been used instead of names of clients and health professionals.

3.3.1.1 Study site

Khokho health centre in Zomba, the Southern region of Malawi, was the main site of the study (see map in Figure 1.1). This health centre was chosen because it is located in Zomba where I am institutionally based. There are about 34 health centres under the Zomba district health offices, 26 of which are in the rural areas of Zomba. Khokho health centre is outside the Zomba urban area. The rural area was chosen because it was thought to be away from the interferences of programmes by other scholars from the health sciences and nursing college, who mostly conduct their in-training practices in the health centres around the city. Such interruptions were avoided by selecting a centre in the outskirts of Zomba city to appreciate the activities of the health centre in their daily routine.

The health centre was chosen purposely in terms of the vibrancy of activities pertaining to HIV/AIDS care and antenatal care (for PMTCT). It was imperative to have voluntary counselling and testing (VCT), ART and PMTCT in one health centre for variety and richness of data. Accessibility from my operating base was also another factor that was considered in selecting the health centre.

The study used convenience (purposeful) sampling to recruit participating clients and health professionals at the health centre. Those clients who were exiting or waiting to enter the counselling sessions and consented to participate in the study were interviewed

or recorded. Purposive sampling considers availability and convenience (Blaxter et al., 2006; Hennink et al., 2011) and depends on how participants fit certain criteria and characteristics as required by the study (Schensul, 2012). In this case, clients attending VCT or PMTCT sessions who consented to participate in the study were targeted. The sampling also considered clients who were willing to stay a little longer for interviews after the medical consultation, since most of the clients rushed to leave soon after the consultations. For the health professionals, the number of participants depended on the professionals available at the health centre during the time of the study. Additionally, it depended on them giving their consent to participate. Fortunately, no recruited participant declined the request to be recorded or to be interviewed.

3.3.1.2. A description of the structure of the clinic

Khokho health centre is located at the hub of a very wide community. It serves about 58 villages around it. It is located close to Khokho trading centre. Khokho is a relatively busy health centre with an average of 3,300 patients or clients attending services in its various departments every month (see Table 3.2). Just like most health centres in Malawi, it offers VCT, ART and PMTCT services in addition to general primary health care. Such a combination of services is good because it afforded me a chance to interview a variety of participants accessing various HIV/AIDS related services. At the beginning of the data collection, in October 2015, the average daily attendance for the health centre was not known, so I conducted a site mapping (Schensul, 2012) to determine the average number. Site mapping also helped me to define how many participants to interview per day during the period of study. Table 3.2 presents the statistics of attendance per clinic or department during the month of May 2015. The report of May 2015 was chosen because it combines statistics from all the departments compared to the reports of subsequent months of 2015 which were fragmented.

Table 3.2: Statistics of the month of May 2015 for Khokho health centre

Department	Attendees	Remarks
Outpatient department (OPD)	2,514	Held every week day, 8am to 4pm (except on the mornings of Tuesday and Thursday to pave way for child and ART clinics respectively)
Child clinic (under-five)	183	Held every Tuesday, 8am to 12 noon.
ART Clinic	142	Held every Thursday, 8am to 12 noon.
HIV Counselling and Testing (HTC)	325	These include voluntary and provider initiated testing such as PMTCT Open every day, 8am to 4pm
Antenatal clinic	103	Open every day. Mondays are for first visits (1st trimester of pregnancy) only, while the rest are for subsequent visits.
Deliveries in Maternity ward	70	The only in-patient department, open 24 hours.
Total attendees	**3,337**	

Apart from attending to patients and clients at the health centre, there are also village under-five and family planning clinics that are conducted by Health Surveillance Assistants (HSAs) in remote villages, within the communities. These are conducted in order to reduce travel distances for clients.

3.3.1.3. Health personnel at Khokho health centre

The health centre has medical personnel, ground workers who clean inside and around the premises, and hospital guards for night hours. Of relevance to the study are all the medical personnel at the health centre as presented in Table 3.3.

Table 3.3: Health Personnel at Khokho Health Centre

Personnel	Number by gender	Duties
Medical Assistant (Health Centre In Charge)	1 Male	• Administrative in charge of the health centre • Attends to patients in OPD, during clinic hours and 24 hours emergency services at the clinic • Administers ART drugs to clients
Nurse/Midwife	1 Male 2 Female	• Responsible for antenatal clinics • Attending to women in maternity care • Male nurse also attends to patients in OPD and helps with administering ART drugs to patients when medical assistant is unavailable • Administering family planning services
Health Surveillance Assistants (HSAs)	11 Male 4 Female	• Conducting under-five clinics at the health centre and in the communities • Administering family planning services in the communities • Leading in environmental health programmes, such as water and sanitation, in the communities • Holding educational talks to patients in OPD and under-five clinics
Senior Health Surveillance Assistant	1 Male	• Overseeing duties of all HSAs at the clinic • Performing all HSA duties as above
HTC Counsellors/Health Surveillance assistants	2 Male 1 Female	• Performing all HSA duties as stated above • Conducting HIV counselling and testing in the HTC clinic
HTC Counsellors	2 male	• Conducting HIV counselling and testing in the HTC clinic • These counsellors were placed in the clinic by Baylor International, an NGO working in paediatric HIV care
Expert Clients	1 male 1 female	• These are ART clients who were trained by DIGNITAS International to model good ART practices • They help in conducting ART clinics • Conducting ART counselling

		• They help with other clinic duties similar to those of hospital attendants below
Hospital attendants – OPD	2 Male	• Registration of patients in OPD • Administering drugs (pharmacy) • Administering malaria tests
Hospital attendants – maternity clinic	3 Female	• Helping with duties in the antenatal and maternity clinics • One of the female hospital attendants is trained in ART administration and assists during ART clinics
Total number of personnel	32	

Table 3.3 details the number and roles of personnel at the health centre, but not all of them participated in the study. The study targeted personnel who were involved in work related to HIV/AIDS during the study. The total number of participating health personnel was nine, who were observed and interviewed and are presented in Table 3.4, which also includes the number of clients who were interviewed.

Table 3.4: Participants at the health centre (interviews only)

Category of participants	**Number**	**Sex**
PMTCT/Antenatal clinic clients	37	female
Health professionals	9	6 male
		3 female
Total	**46**	

Ethical procedures were followed in the recruitment of all these participants. The details of the ethical considerations are described in the next section.

3.3.2 Ethical considerations

This section describes the procedure undertaken to obtain ethical clearance for the study, offices involved, the process of accessing the study site and seeking clearance from study participants.

3.3.2.1 Ethics Clearance Procedure

All required procedures were followed to obtain ethical clearance before embarking on the project. A proposal of the study was presented to the University of Warwick, Centre for Applied Linguistics Graduate Progress Committee for ethical approval. Ethical approval was granted by Graduate Progress Committee of the Centre for Applied Linguistics (CAL) in August 2015 (Appendix 14). Furthermore ethical clearance was sought from National Committee on Research in the Social Science and Humanities (NCRSSH) of National Commission for Science and Technology (NCST) an agency that is responsible for overseeing research and ensuring ethical considerations in all research taking place in Malawi (Appendix 13). To gain access to the health centre, approval was also sought from District Health Officer (DHO) and District HIV/AIDS Coordinator both of whom operate at the District Health Office.

3.3.2.2 Presenting information and seeking consent

An information sheet alongside the consent form was presented to healthcare professionals and clients (see Appendices 1 to 4). The information and consent forms for healthcare professionals were in English because English, as an official language, was understood by all healthcare professionals. The information sheets and consent forms for clients at the health centre were translated into Chichewa, a language that is understood by all in Zomba. The information was given orally to most of the participating clients, because it was generally preferred to do so. While all participating health professionals were given the information sheets to read by themselves.

The information sheet explained the study in lay person's terms, procedure to be undertaken by the study, protection of participant's privacy, assurance to the participants that there will not be any physical harm during the data collection process, use of the data pertaining to each group of participants, and they were informed of their freedom to opt out of the study at any point if they were not willing to proceed or participate. Another sheet consisted of details where the participants had to sign when they consented to be interviewed, recorded or observed.

All recruited participants (for interviews and recording of counselling sessions) were presented with the information and consent forms. The participants were asked to present a written consent, and where they were not willing or able to sign, a verbal consent was sought instead. In most developed countries it is expected to have a study

participant present written consent; however, in some developing countries culturally and due to low literacy levels, it is not easy to obtain written consent from study participants (Shaibu, 2007; Upvall and Hashwani, 2001). Most study participants felt it was enough to give verbal consent. The signing of consent may place participants in an awkward position if they are unable to write. Furthermore, signing a document to participate in a study may sometimes be regarded as legally binding, which leaves many participants feeling unwilling to append signatures (Upvall and Hashwani, 2001). As a result, in cultures where oral communication is considered sufficient in building trust, most participants regard a verbal acceptance to participate in a study as entirely adequate.

Where written consent was not given, the information sheet was read out to each participant and each participant's oral consent was recorded, and the manner of the consent was documented on a separate consent form for the researcher's records. The study was aware of some challenges in seeking consent that may arise in this African context, due to low education levels (de Vries et al., 2015; Henderson et al., 2007).

A similar consent seeking procedure was done to audio-record group counselling sessions, where at the beginning of each session information was orally shared to all and individuals were handed the consent forms for signing. Most clients preferred to give verbal consent, and only about a quarter of the participants signed the consent forms.

3.3.3 Piloting phase

A pilot study was conducted during the first couple of weeks of the field research. The pilot study was meant to test the research instruments, particularly the interview questions for clients and health professionals; consent seeking modalities, the audio recorders; and the general interaction with people during the study. There were some changes made to the format of interview questions and recording styles following the pilot study (See Appendix 15 for a detailed presentation of the methodological outcome of the pilot study).

3.3.4 Data collection techniques

The study's data collection techniques included: audio-recordings of group counselling sessions and educational talks, conducting in-depth interviews, collection of HIV/AIDS

related clinic guidelines and documents, and observations of activities surrounding HIV/AIDS care (see Table 3.1).

The study recorded all group counselling and health education sessions, and also included observations of various activities around HIV/AIDS counselling that were held at the health centre and in the communities during the period of the study. As stated earlier, the activities at antenatal clinic in the PMTCT programme are the ones that are of main interest and analysed in this study.

As seen earlier, in Table 3.1, there are different sets of data that were collected. As the research focus of this study evolved recursively, taking into consideration in particular the sometimes unpredictable conditions encountered during fieldwork, the focus of the analysis emerged as being upon the audio recordings of PMTCT group counselling sessions. However, observations of other sessions, such as general antenatal educational talks and activities around the antenatal consultations, were also relevant since they enabled an understanding of how various contexts in the clinic related to the audio text. Moreover, interviews with the participants and analysis of documents guiding the interaction were essential in understanding the context of interaction from the participants' perspective. These different text types are included in the study to address the phenomenon of intertextuality in analysing the HIV/AIDS discourse. This is in line with Lupton's (1992) study on discourse analysis which illuminates the importance of considering different text types in exploring ideologies and discourse practices in the domain of public health, for instance, how the discourses of HIV/AIDS are reproduced by different actors. The data collection techniques and relevant data sets are described in more detail below.

3.3.4.1 Audio recordings

All the formal interviews with healthcare professionals and group counselling sessions were audio recorded. Consequently, audio recordings from group counselling seesions were the core data for this study. Voice recording is useful in that it helps one to keep the conversation's transcripts and refer to them when needed. Moreover, when available for transcription it may provide some features that were not noticed before (Silverman, 1997). Informed consent to audio recorded conversations and interactions was sought from all clients and health professionals involved in a given session (as in 3.3.2.2).

3.3.4.2 Observations

Group education and counselling sessions and activities surrounding HIV/AIDS care at the health centre were observed in order to have a clear context of the audio group interaction. Clients were also observed during clinic waiting times. The study adopted the technique of participant observation to give a clear view of the activities around HIV/AIDS care as they happened at the clinic. This is a technique that is common in ethnographic studies and was essential to the study. Participant observation is about watching the activities of the participants and in some cases joining in, and it involves taking notes of what is seen and heard (Rubin and Rubin, 2012); so field notes were obtained and they contribute to the data analysis (see Appendix 10). Observation is also used in most studies in health care because of the need to have empirical data that can inform practitioners to achieve better practices (Pope and Mays, 2006), and to supplement the data obtained from interviewing participants and audio recordings.

Furthermore, observations of 'backstage' discourse, the everyday talk of health professionals that took place at the health centre when they are not attending to clients (after Goffman, 1959; Sarangi and Roberts, 1999) are included in the study. Activities such as ordinary conversations in the institution were observed, in order to understand the reproduction of HIV/AIDS discourse and how the health professionals construct the client outside the consultation room. Inclusion of 'backstage' talk was vital to the understanding of the health professional's knowledge in another interactional context. The backstage talk brings to the study the health professional's perspectives of the clients and care experiences compared to those of the 'front stage'; which may be performed with a realisation of public scrutiny (Goffman, 1959).

Observation is mostly used in qualitative studies because it reinforces the idea of studying people in a natural setting as opposed to creating experimental settings (Pope and Mays, 2006; Saldana, 2011). By observing, it was possible to have a clearer perspective of healthcare clients and health professionals' experiences and this was supplemented by what they actually stated during the interviews. Observation was also helpful in participant recruitment in some cases, where after observing the clients I was able to identify those I could approach for interviews. Participant observation prior to interviews enabled me to familiarise myself with the setting and assist in asking relevant questions (Rubin and Rubin, 2012). Thus, before interviewing the healthcare professionals it was important to observe, be part of the team and gradually understand

their practices for a more focused interview. Consequently, formal interviews with the health professionals were saved for the last two weeks of the study.

3.3.4.3 Interviews

Interviews formed another part of the study to support the audio data from the group counselling sessions. The interviews were held with 37 VCT and PMTCT clients and eight healthcare professionals involved in HIV/AIDS at the health centre (see Table 3.4). The interviews with selected clients were held following each group counselling session in order to hear their perceptions of the interaction (see Appendix 6). Interviews are an effective way of acessing the participants' "perspectives, feelings, opinions, values, attitudes, and beliefs about their personal experiences and social world" (Saldana, 2011: 32) as they relate to the phenomenon under study. In drawing on some elements of the ethnographic approach, interviews were also useful to this study because they provide the participants' perspectives on the interaction and these shed light on the interpretation of the audio texts (Copland and Creese, 2015).

The study employed conversational and semi-structured interviews for the two categories of participants (clients and health professionals). Rubin and Rubin (2012) describe conversational interviews as the brief unstructured way of asking questions, usually spontaneous chats. These occur as the researcher converses with a participant during participant observation and during the regular chats the researcher and participant may move into topics that are relevant to the research. These conversational interviews were held with clients on the waiting bench followed by semi-structured interviews after they attended the counselling sessions. All the interviews were immediately followed by a time of recording the noted points in a notebook.

Some interviews with four health professionals that I worked closely with were also held in an informal manner and gradually during the regular interaction for the entire period of field work. This was followed by a more formal semi-structured interview towards the end of the study. The conversational interview is one way of gathering information that is applied in ethnographic studies. It allowed a natural conversation during the normal activities of the participants (Hammersley and Atkinson, 2007) and enriched the data (Rubin and Rubin, 2012). Nevertheless, the informal interviews and chats were somehow limiting because they relied on memory as I recorded responses after a conversation, but this method is acceptable for studies of this kind where

flexibility is essential (Copland and Creese, 2015). Moreover, sensitivity during the interview process, in this case on the use of the research instruments in relation to the context (e.g. Mann, 2011) was very important. Using note taking as a tool for recording interviews, however, required discipline by writing notes soon after the event and to remember the responses as accurately as possible.

The conversational interviews paved the way for semi-structured interviews after the clients attended counselling and, towards the end of my stay at the health centre, to interview the health professionals. Semi-structured interviews are said to be flexible in that they contain open-ended questions from which issues can be covered in detail and follow-up questions and probing can be employed (Britten, 2006; Kroger and Wood, 2000; O'Reilly and Kiyimba, 2015). Moreover, for this study, semi-structured interviews were useful in that they allowed the participants and me to discuss and develop some themes that were not expected but emerged during the interviews (Mason, 2002).

Consequently, semi-structured interviews were held with two nurses, one medical assistant, four HTC counsellors, and one expert client (health worker) to hear their views and assessment of clients' knowledge about HIV/AIDS as experienced during their interaction with clients. Furthermore, the 37 clients were interviewed to hear their perception of the clinic as a knowledge source, their views on interaction, and to learn about other sources of information that they used to obtain knowledge about HIV/AIDS. The questions were more to do with opinion, experiences, and perceptions as the participants were asked to share their interactive experiences (e.g. Britten, 2006). The list of the interview questions is presented in Appendices 5 and 6.

The interview process required some reflection on the techniques and reflexivity on my role and status as a researcher (see Mann, 2011; 2016) in the context where my status, as a student who had travelled from abroad, had an effect on the flexibility of the participants during the interviews. Thus, after the piloting phase there were some changes to the questions and approach because of several observations, *inter alia* the effect of my status, lack of private space for interviews, and limited time for interviews that most clients had after lengthy procedures during the consultations (see Appendix 15 for further details). Hence I found conversational interviews with clients to be a practical addition to the formal interviews. In addition, the use of recorders for interviews with clients was dropped due to the apparent discomfort that it caused to

most of them. More details on my role as a researcher and how it affected the data collection process are given in section

3.3.4.4 Examination of written documents

Document analysis was another method used in the research to support the interpretation of audio data from the group counselling sessions. Document analysis "involves examining documents…and just about anything that appears in written form, as well as pictures and visual recordings [from archives]" (Rubin and Rubin, 2012: 27). Documents pertaining to HIV/AIDS care at the clinic were collected for analysis. The examination of different texts was to investigate the intertextuality which enabled a critical understanding of the relationship between texts in the production, reproduction and transmission of HIV/AIDS knowledge. In this way observations, documents, and interview data interacted with each other to provide a plausible analysis of the constructed knowledge by different participants (Cameron, 2001; Fairclough and Wodak, 1997; Flowerdew, 2008). The documents provided comparative texts for interpretation of information in the counselling sessions; an understanding of institutional order; contextual background to the spoken interaction; and the practices followed by the professionals. The documents also guided the interviews with health professionals later on.

The following table, Table 3.5 gives a list of relevant documents for the analysis of HIV/AIDS discourse that were obtained from the Khokho health centre. All of these documents were in English except one notice for patients which was in Chichewa.

Table 3.5: Hospital documents on HIV/AIDS

Document type	Location	Language
HIV/AIDS Counselling and testing guidelines for Malawi (Ministry of Health, 2004)	HTC Counsellors' office	English
HIV Testing and Counselling: Training for HIV Counsellors (Ministry of Health, 2007)	HTC Counsellors' office	English
HTC Protocol Booklet (Ministry of Health, 2013)	HTC Counsellors' office	English
HTC Job Aides (Ministry of Health, 2014)	HTC Counsellors' office	English
HIV Testing Assistant Manual (Baylor Tingathe Community Outreach Programme, 2015)	HTC Counsellors' office	English
Poster "Key messages on viral load and treatment failure" (see Appendix 6)	On the wall of the main waiting area	English
Chart "HIV/TB clinical road map" (see Appendix 7)	On the wall of the main waiting area	English
Chart *"Kalozela wa kulondola omwe sanabwere kuchipatala mwandondomeko"* (Clinical road map for those who have not adhered to treatment) (see Appendix 8)	On the wall of the main waiting area	Chichewa
Clinical road map for PMTCT (see Appendix 9)	On the wall of the main waiting area	English

Selected charts and notices which were displayed on the noticeboard are included in the appendices (Appendices 6 to 8). Some of the notices for patients and health professionals contained names and have not been included to avoid identification of the hospital and the hospital personnel.

3.3.5 Description of data

This section describes selected data sets that were obtained and analysed for this study (see Table 3.4). Each data type represents a distinct interactional context.

3.3.5.1 Group counselling sessions

Group counselling sessions were the core data for the study and these were audio recorded. Group pre-test counselling sessions are held for pregnant mothers during antenatal visits. Antenatal first visits are conducted on Mondays only. These sessions were for women in the first trimester who were in their first visit of antenatal care. In this case some who were in the second and third trimester of their pregnancy but in their first visit to the antenatal clinic were part of this group. Pregnant women require an HIV test as part of the PMTCT. As per requirements, HIV testing is preceded by a counselling session. HIV pre-test counselling is conducted with a group before testing them individually in order to save time. Seven HTC group counselling sessions in the PMTCT programme were recorded. One counsellor conducted these sessions one at a time. The number of women in attendance ranged from 14 to 20 on all seven occasions. The sessions lasted in the range of 25 to 30 minutes.

The subset of data described below is related to the antenatal clinic and HIV activities that some of the pregnant women and mother-infant pairs attended. Observations of these sessions contributed to the understanding of the practices of the clinic.

a. Antenatal educational group talk

Pregnant women at different stages of antenatal visitation are offered a health educational talk during the visit. An educational talk of about 25 to 30 minutes is given by a hospital attendant or a nurse. The nurses have a duty roster for conducting presentations with a weekly theme of focus. On separate days, the health professionals tackled topics on family planning vis-à-vis HIV/AIDS, maternal health, care for a new-born baby, HIV/AIDS, and other sexually transmitted infections (STIs). Pregnant women attending the visits for the first time go for HIV counselling and testing after the talks.

b. ART group talk

Clients attend ART clinics on Thursday morning; the programme starts at 7:30 am. Each client collects their ARV dosage on a monthly basis. There is an average of 35 ART clients at a time, according to the clinic records. During ART clinics, an educational talk of about 15 to 20 minutes is given by an expert client, hospital attendant, or a nurse (only the ones who have been trained in ART programmes are

involved). The talk borders on what they are required to do when taking ARV drugs, on living positively with HIV, nutrition, and all issues related to taking ARV drugs.

c. Educational talk for clients starting ART

All clients visiting the clinic to start ART are offered a separate ART introductory talk. One of the expert clients (a health worker) gives this talk. The ART introductory talk takes approximately 20 minutes. I attended two of these introductory talks and on each occasion there were three new clients and their guardians. Each client is required to bring a guardian at the start of ART so that they undergo the ARV drug introductory lessons together. Guardians are meant to support their wards in following ART recommendations and ensure treatment adherence. On some occasions the guardians are allowed to collect drugs on behalf of the client, especially when the client is unable to do so.

d. ART educational talk for those who did not adhere to ART

Those who did not collect their drugs at appointed dates and missed taking drugs on more than one occasion are required to undergo a separate educational talk. The hospital authorities take the cases of not adhering to treatment seriously because skipping ARV drugs for a particular period has serious negative repercussions on progress in HIV treatment. As a result, the health professionals take the client through a lesson to remind them of the dangers of missing treatment. There were at least four clients undergoing these lessons each of the weeks I was at the clinic. The health professionals in this clinic referred to these lessons as "lessons for defaulters" and clients who do not adhere as "defaulters". The length of time for these talks is 15 to 20 minutes. A special message is also given in form of a poster, placed on the wall in the waiting area, to indicate the action that the hospital takes for those who do not adhere to treatment (see Appendix 8).

3.3.6 Narrative of my position as a researcher

There were several experiences relating to my role as researcher during the data collection period at Bimbi health centre which required critical reflection and reflexivity as I drew a number of lessons in relation to the collection and analysis of data (Mann, 2011; 2016; Steier, 1991). As a researcher I had to be part of a team of health personnel on a daily basis during this period, which was essential in building a rapport with the

participants. I worked mostly with the health professionals in the HIV/AIDS and the antenatal clinic because they usually work together in the PMTCT programme. Knowing that I could not be involved in medically related tasks, I learned that as a researcher I should not restrict myself to my role of collecting data. But I had to be involved in the day to day activities of the clinic which did not require any medical skill, according to what is done in ethnographic approaches, but enabled me to focus beyond the core interactional data (e.g. Roberts et al, 2014). I helped with the unskilled tasks, e.g. welcoming clients to the counselling sessions, cleaning the counselling room, preparing the clients' waiting area in the courtyard by arranging chairs in the mornings before the start of the sessions. I had to arrange seats for the HCT clients outside because sometimes the benches were taken off the HTC waiting area, and on some mornings I had to fetch them back. I mostly welcomed clients outside the HTC centre and negotiated with counsellors to attend to them when there were delays in opening time.

On a few occasions the counsellors asked me to conduct a counselling session because they believed that I had learnt enough to do this. I explained my lack of counselling skills and encouraged them to proceed with their work. Such a request was received favourably on my part, inasmuch as - conducting counselling sessions was not one of my objectives - it gave me a chance to be part of their team. I felt included and it was evident that we were relating well. At other times during ART and HTC counselling the health professionals asked me to add to, or comment on, the talk. During the first days of my stay I avoided commenting, but with their insistence over time, I opted to comment on points that were less technical and sometimes chose to simply reiterate their points. In other cases, I simply voiced agreement with what they had said. This involvement was encouraging in that I realised that my position as a researcher had gradually changed from that of an outsider to that of an insider, thereby enabling me to get a more insider perspective of the study site (Riazi, 2016). However, my involvement also required reflexivity regarding my role: that as someone who entered the site as a researcher, my role had changed to that of 'participant observer' (Riazi, 2016:121). But, it was still necessary for me not to interfere with the everyday activities of the participants or alter their talk in anyway while interacting with the research site (Steier, 1991).

a. Mediatory role

On occasion, I was sometimes mistaken for a member of the medical personnel. On several cases patients approached me to explain their medical issues and I had to lead them to the right department. On two separate occasions, two workers at the health centre, who did not know my role in the clinic referred patients to me when the medical assistant's office was closed for lunch and on one morning when the OPD was closed.

The environment also prompted me to act as a mediator for patients in some cases. For example, one morning when ART clinic was in progress, I negotiated with a nurse in attendance to attend to a patient who had approached me due to an asthmatic attack and was in great distress. I explained to the nurse how that patient would have a difficulty to wait until after lunch for medical attention. Fortunately, the nurse who was at that time busy administering ART drugs, was understanding and attended to the patient. Largely, it was disturbing to see OPD patients lying on benches waiting for the reopening of the clinic when it was closed for lunch or during ART or child clinic only session, the reopening of which was usually about 2pm.

Sometimes clients at the HTC were not promptly attended to and, as a result, I acted as a mediator between the clients and the counsellors, negotiating punctuality in opening times, requesting the counsellors to attend to the clients, or alerting the counsellors when there was a client to be attended to. This mediation was tricky because the clients' waiting bench was in full view of the HTC, and clients could be seen by the health professional, yet they were sometimes not promptly attending to the clients.

Sometimes clients complained to me about the long waiting times and lack of consideration about time on the part of the counsellors. One client thought I could attend to him, he pleaded with me by alluding to the fact that I had been around HTC for some time, and therefore I could also conduct HCT. I realised that clients had a lot of expectations from me, despite explaining my position to them. More often they enquired if I could assist them even by talking to the medical personnel on their behalf so that they obtain timely assistance. My involvement with clients as a 'mediator' enabled me to develop a more 'authentic' understanding of the core interactional data, i.e., by understanding the related contextual elements in terms of time, space, and the

relationship between health professionals and clients outside the counseling room (Hammersley and Atkinson, 2007).

b. Familiarity with the health professionals

I managed to develop a good rapport with the health professionals which eased my movements across various contexts in the research site. The familiarity with the partcipants enabled me to easily decide the areas where I needed to spend more time and research with more depth without any restrictions (e.g. Hammersley and Atkinson, 2007) and I was able to easily ask the health professionals questions in form of natural conversations (Rubin and Rubin, 2012). Nevertheless, my familiarity with some of them also had a potential to affect the ethical considerations of the study. For instance, over the course of the study two of the health professionals did not consider seeking informed consent from clients as important. They did not approve of the need to seek consent from clients before recording each counselling session and, on several occasions, suggested that we proceed to record without the awareness of clients. One of them reasoned that clients were not free to share a lot about themselves during the sessions when they know that they are being recorded. She thought the gadget could easily be hidden and not be noticed by clients. I explained the importance of seeking consent and proceeded to introduce myself and seek consent before the sessions. However, on some occasions one opted to take over the task of introducing me. She introduced me as a fellow counsellor – 'one of them' – that I was just assisting in the work and learning more about it hence I was recording for educational purposes.

Her method of seeking consent also posed an ethical challenge to my approach when she demanded partcipation from the clients by asking: "Is there anyone who does not want her to do her work?" "Anyone opposing the recording?" I found this challenging because it was not in line with ethical guidelines. As a result I just had to be firm and made sure that I take complete control of the task of introducing myself and the study just as the clients settled in HTC room or outside as they waited, wherever there was a chance to do so.

c. General economic hardships

Observing the economic hardships that the health centre and most patients were facing was also disturbing for me. Lack of essential resources for the hospital emanates from the Ministry of Health, and trickles down to the grassroots. The first problem was lack of ambulance facilities to transport critically ill patients and pregnant mothers from the health centre to the central hospital in Zomba town. The arrangement is that the clinic calls for the ambulance to come from the central hospital for emergency referral cases, but mostly there were fuel problems; hence it came intermittently and only for pregnant women. Guardians were therefore responsible for ferrying patients by hiring vehicles or bicycles. In most cases during the time I was there, some pregnant women had to wait, sometimes more than 18 hours, before the ambulance arrived. So, mostly patients were advised not to wait for the ambulance but find their own means of transport to get to the central hospital. Thus, on several occasions I had to drive patients to the referral hospital in Zomba town. For some cases, I was compelled to give poorer guardians some money for food during the admission time since the hospital does not cater for guardians and there are limited meals provided for patients.

More disturbing were the times when there were no drugs for malaria and general infections, a malaria drug LA and antibiotics were out of stock, handicapping the OPD in its duties. Malaria is the leading cause of hospital visits in at the health centre (for instance in May 2015's register 632 out of 2,514 OPD cases were treated for malaria). During the shortage of the drugs, patients were simply given prescriptions to go and buy their drugs elsewhere although most of them could not afford it. Lack of drugs reduced hospital attendance to almost half during a particular week. When people knew that there were no major required drugs at the clinic, they did not see the need to go the hospital (conversation with Medical Assistant at the hospital). I was very touched to learn of two deaths of under-five children who had severe malaria but could not receive treatment because of the shortage. This experience enriched my understanding of the resource context of the institutional talk which changed from the one I had as an outsider upon entry into the research site, and made more sense as I obtained a holistic view with an insider perspective.

d. General reflections

Overall, I felt included at the health centre. The social interaction with the institutional context enabled me to have an insider perspective of the data during the period of collection and later on facilitated an in-depth interpretation of the data during analysis (Hammersley and Atkinson, 2007; Riazi, 2016). I was welcomed as part of the care team and that created a conducive environment for the study. It was interesting that I ended up doing more than just collecting data, meaning that I had to be flexible as a researcher by not just focusing on the data collection tasks. It was distressing to see that there was a lot that I could not change, i.e., patients who needed urgent treatment and drugs, lack of urgency in attending to patients, and general inadequacy of medical resources. Nevertheless I tried to assist where I could, for instance, providing 'ambulance' services to patients or being requested by health carers to carry the patients to Zomba central hospital made me feel helpful. Running the small errands at the HTC centre also helped me to be part of the team. I also regularly granted a lift to one of the HTC counsellors and two health surveillance assistants who lived closed to Zomba town. Other hospital personnel also occassionally asked me for a lift to get them to town for personal errands after work. A number of the health personnel considered my going to Khokho an opportunity for free transportation to an area that has no reliable transport, a comparably high fare, and an invariably longer duration of travel. I therefore enjoyed being part of the team at the health centre. I have since maintained contact with four of the health professionals from this clinic which potentially gives me a chance to easily get back to the site for feedback workshops later on (see section 8.3.1).

The next section below (Section 3.4) describes how the data is analysed within the theoretical framework of IS and supported by studies from the CDA tradition.

3.4 Data analysis

Earlier, in section 3.2 of this chapter, it was indicated that the research paradigm that the study is adopting is a constructionist one, and that IS is the main theoretical framework adopted in this paradigm while the critical bit of CDA is selectively used to provide explanations of power assymetries and reproduction of social and institutional structures where relevant. Similarly, in Chapter 2 (literature review), I laid out the theoretical perspectives to the study of discourse, and healthcare discourse in particular,

in how social structures are related to the interaction in order to situate the current study. This section explicates the analytical approach in more detail.

3.4.1. Applying interactional sociolinguistic approaches to the study

Studies that investigate healthcare interaction by using an IS analytical framework employ all or some of the following methods: audio or video recordings of interactions, conducting a micro analysis of recorded conversations and interviewing the interlocutors following audio-visual recordings; as in this study, these are often supplemented by ethnographic observations (Candlin, 2006; Heath, 1992; Maynard, 1992; Hamilton, 2004; Sarangi and Brookes-Howell, 2006; Strunck and Lassen, 2011; Zayts and Schnurr, 2014; Zayts et al., 2012). The recorded interaction of group and one-to-one counselling sessions from the health centres was transcribed and analysed using an IS framework. The transcription symbols used in the paper were simplified conventions that are typically used in conversation analysis and the list was adapted from Cameron (2001: 36-40); Kroger and Wood (2000: 193-4); and Silverman (1997: 232-233). Appendix 1 presents the transcription conventions used to transcribe audio data for this study.

A few studies were selected as particularly useful in guiding how I analysed the data for this study. The key informative ones were Sarangi (2000, 2010a, 2013) Roberts et al. (2004; 2014), and Candlin, (2006). These studies were drawn upon because of their illustrative and relevant engagement with interactional data from healthcare consultations. Sarangi (2010a) shows how structural mapping of medical encounter in the context of genetic counselling is done, according to the purpose of each phase of the sessions e.g. agenda setting, checking knowledge, giving information, explanation of procedures or summarising talk, among others. The mapping of various phases of the talk is also done by Roberts et al. (2004) in a study of primary consultations for patients with non-English backgrounds in the UK. Their study maps the phases in terms of purpose of utterance, description of symptoms by also including descriptions of person's stance – affective and epistemic. Roberts et al. (2014) also illustrate a linguistic analysis of thematic features of talk e.g. alignment or misalignment, rapport, empathy, and power.

Thus, in my analysis, a structural mapping of the counselling was done according to themes in what Sarangi (2010a) refers to as a "theme oriented analysis" which relates

to the activity types[2] of the healthcare discourse. There are focal themes derived from the activity types of healthcare interactions which in turn provide codes for interpretation, e.g. the theme of patient-centredness is derived from some participatory frameworks such as alignment, client-autonomy, collaboration or shared decision making. The transcripts of the audio recordings were analysed according to emerging categories that define the function of each phase of the clinical talk (see also Burton, 2006; Maynard, 1992; Robinson, 2006; Silverman, 1997; Slade et al., 2008.). Recognition of categories and the function of various utterances in institutional talk gave guidance for a clear textual analysis. In this case, HIV counselling and educational talks are analysed according to the function of each step of talk, namely sharing basic information about HIV/AIDS, explanations, discussions, advising or talking about test procedures.

Following this structural mapping, a more subtle mapping was done in terms of the textual details e.g. at the level of phrases, words, turn distribution, turn frequencies, turn sequencing, or duration of individual turns. In addition, the linguistic resources used by each interlocutor for accomplishing the aims of each utterance were also coded, called by Sarangi linguistic devices (2010a). Therefore, the analysis further focused on the linguistic devices that the interlocutors use to achieve these interactional aims e.g. questioning, interruptions, repetition, metaphors, storytelling, choice of words. The analysis also included subtle linguistic features that are significant such as prosodic features (stress and intonation). Some of the features that were considered in the analysis were interlocutors' responses – such as verbal, hesitations and pauses – and other relational features (see also Gordon, 2011; Cameron, 2001; Drew and Heritage; 1992; Gumperz, 1982). For instance, responses such as a simple 'yes' or 'mmh' by the client help to construct power and knowledge imbalances and these were compared to clients' responses in form of statements, comments, or volunteering of further information (Candlin, 2006). The interpretation of the linguistic features was possible by making inferences to background knowledge or by simply making actual references to the talk, as done by conversation analysts.

[2] 'Activity type' largely characterises 'setting', the domain in which language is put into use, e.g. court hearing, medical tests while discourse type characterises the form of the talk (e.g. advising and narrating stories) which is manifested during interaction in a particular domain (after Levinson, 1992; see also Sarangi, 2000). Sarangi (2000: 2) refers to 'interactional hybridity' whereby activity type and discourse type may overlap in some settings, for instance in genetic counselling. He describes genetic counselling as a type of talk that may occur in various activity types, but also draws on different discourse types.

Therefore, the features of speech during HIV/AIDS counselling, by both the client and health professionals, had a contribution to make in understanding how HIV/AIDS knowledge is reproduced and negotiated. For a meaningful analysis, IS starts from the talk before going to the immediate context or background, thereby providing a bottom-up approach to textual analysis (Rampton, 2010). As such, for an immediate institutional contextualization of the analysis of core interactional data, interviews, hospital documents and observations, as enabled by ethnographic approaches, are also included (Roberts et al., 2014). The interview data and analysis of documents are important in IS as they help in explaining some of the activities observed in interaction. Interviews were analysed according to the emerging themes and language choices of participants. Some scholars (e.g. Mann, 2011, 2016; Richards, 2009) argue that interview data, for those who use mixed-methods in applied linguistics, are often given less attention. They suggest that the data should be analysed like spoken interactions because interviews are also "sites of social interaction" (Mann, 2011: 8; 2016). So, for this study, I utilised interview data of clients and health professionals to support a range of observations in the talk. As used by other scholars in IS, the interviews act to check "post-visit" perceptions (e.g. Hamilton, 2004: 61). The approach to interview data is further detailed in the approaches to CDA in the next section, Section 3.4.2.

3.4.2 Supplementing IS with CDA's analytical approaches

CDA was applied in the analysis of the discourse of health care by considering different levels of the text production and reproduction, and by relating an institutional-situated reproduction and negotiation of meaning to the broader institutional and social structures of discourse. The application of the approaches of CDA for data analysis in relation to the various sources of data in the study is further detailed below.

CDA allows for a wider analysis of the data beyond the interaction by helping to understand the prevalent power dynamics and inequalities that exist in the wider social structure that encompasses health care (Slade et al., 2008; Wodak, 1997). In this case CDA was used to analyse the discourse, more broadly, as a social practice by including a "critical examination of cultural and social practices" (Kroger and Wood, 2000: 21). Of key relevance to the analysis was van Leeuwen (2008; 2009) who presents how various discoursal features are employed to represent social practices and social actors in a text. He illustrates how legitimisation of social practices is done in official documents, for example, through recontextualisation, agency shifts (from one actor to

another), and passivation or activation of agency in relation to particular social action. The key features identified in the analysis i.e., 'legitimisation' 'recontextualisation' and 'intertextuality' were partly drawn upon from van Leeuwen's (2008) analysis of social practices.

The interpretation of documents and transcribed texts was further conducted by borrowing from Fairclough's (1992, 2003) procedures of analysis by categorizing the text at a socio-cultural level, and discourse practice level. Such a multilevel analysis of discourse is also employed by McIntyre et al. (2012) in analysing bodies of knowledge and discourse used by various groups in reforming maternity care delivery. It presents the possibility of analysing various levels of data and enables comparisons to take place. While the analysis that follows does not present the discourse levels programmatically it should be noted that this analytical framework was flexibly adapted to supplement IS approaches in terms of the critical interpretation of institutional and social representations.

The transcripts of interviews held with clients and healthcare professionals, HIV/AIDS counselling guidelines, NAC guidelines to HIV/AIDS care, and health centre documents pertaining to HIV/AIDS care were analysed at the discourse practice level (mainly presented in Chapter 4). The themes emerging from the interview transcripts were compared with clinic guidelines emerging from the document analysis. This discourse practice level required a consideration of questions such as, who are the actors, the patients and the beneficiaries of the presented information, and at what level is each of them operating (van Leeuwen, 2009)?

Another level that was considered is the social-cultural level. This level provided a broad background to the institutional, organisational, ideological and societal structures operating behind the texts (mainly discussed in Chapter 6). Analysis at the social-cultural level guided in the identification of various discourses, and how they are reproduced (textual level), showed the relationship these have to the maintenance of social structures and realities (Aulette-Root, 2010). Stories heard from conversations with health professionals and clients about the Khokho area and the community in general were related to this analysis. Analysed documents from the discourse practice level were also referred to at this level of analysis to understand the contexts of occurring talk, how specific actors are positioned in the discourse, and how the different discourses of HIV/AIDS are represented by different actors (Waldorf, 2013).

The use of CDA approaches in health care has been illustrated by Smith (2007) in her study of policies in healthcare practice, as represented in the media in Australia. By analysing multiple layers of discourse, she mapped the structures around the debates of nurse practitioners and various identities. This has also been done by McIntyre et al. (2012) in which they applied a CDA approach to analyse how power relationships among stakeholders' debates on reforms of maternity services are represented in print media in Australia. Wodak (1997) also argues for the relevance of CDA to the study of doctor-patient communication. In her analysis of medical interaction in a German hospital she illustrates how power is exercised by physicians during medical consultations: by interruptions, control, and disruptions of consultations by other health practitioners. She highlights how power is a product of the social and institutional structures. The current study was interested in not only the relationship of social and institutional structures and discourse of health care but also in the role of human agency in the interaction. Thus, this study found some of the CDA approaches relevant to supplement the main approach of IS, mainly because more CDA studies demonstrate a critical analysis of social and institutional structures and how they are reproduced and represented in the discourse than is found in IS studies (e.g. van Leeweun, 2008; Fairclough, 2010; Slade et al, 2008; Wodak, 1997).

Several scholars also illustrate how CDA is used to fill some analytical gaps in studies that employed more than one analytical approach. One scholar of workplace discourse illustrates a successful combination of approaches of IS with those of CDA and pragmatics to account for power and gender in professional discourse (Mullany, 2007). Another study of communication in emergency departments in an Australian hospital utilises the approaches of CDA, sociolinguistics and systemic functional linguistics in order to relate non-linguistic features and linguistics (spoken interactions) between patients and healthcare practitioners (Slade et al., 2008). Slade et al. (2008) researched spoken interactions between healthcare professionals and patients in emergency departments, and extended their study to knowledge discourses about emergency communication in the wider context. In another study, Angouri and Wodak (2014) illustrate how CDA, particularly the discourse historical approach, is utilised for an analysis of multiple layers of context to analyse newspaper articles and readers' postings on Greek recession. They show how participants do "interactional work," as a linguistic enactment of context, within a context that is constitutive of power asymmetries (p. 547).

These features of the talk – at discourse practice and social-cultural levels – were used to understand how HIV/AIDS knowledge and related social structures are constituted, what relational function the propositions present across various actors and how identities are linked to emerging voices of the participants in the texts (e.g. Fairclough, 2010; van Leeuwen, 2008). Therefore, as health information is presented in the different genres at the healthcare centre in Malawi, these were analysed from the standpoint of these critical perspectives upon the functions of language and discourse.

3.5 Chapter conclusion

This chapter has described the methodology undertaken by this study. It has explained the research paradigm, the methods of research from fieldwork to data analysis, ethical considerations and the theoretical framework that guides the study in relation to the kind of collected data. On the surface, the analytical methodology of IS, supplemented by CDA and ethnographic approaches undertaken by this study might appear too challenging for a coherent analysis. However, thorough reflection on what each piece of the data contributes to the understanding of the discourse of HIV/AIDS within this study context led to an enriched analysis. Thus, by utilizing IS approaches Chapter 4 will address the notion of reproduction of knowledge; Chapter 5 will address the notion of negotiation of knowledge in the talk; while Chapter 6 will adopt a more critical angle by drawing on CDA studies in order to interpret how social and institutional structures relate to the interaction. The next chapter, Chapter 4, presents the analysis of the findings, starting with interpretations of the activity of reproduction of knowledge about HIV/AIDS in this study context.

Chapter 4: Reproduction of knowledge in antenatal HIV group counselling talks.

4.1 Introduction

This chapter presents an analysis of the discursive practices of participants in the context of antenatal group counselling and educational talks at Khokho health centre. The guidelines of counselling by the Ministry of Health recognise the need for client-focused interaction between the health professional and the clients on the one hand, and the information giving role of the health professional on the other. Counselling is considered very important for every client to undergo before having an HIV test in the Malawian context. The health professional is required to give information to the clients and a large part of Malawi's counselling protocol encourages a mode of discussion between the health professional and clients (HTC protocol booklet, 2013; HTC guidelines for Malawi, 2004). The discursive practices of the participants in pre-testing counselling talks are analysed in order to understand the processes through which health practitioners and pregnant women reproduce their knowledge about HIV/AIDS. Focusing on reproduction of knowledge is a way of understanding each participant's utilisation of information in the HIV/AIDS counselling talk at the health centre. It is necessary to include both the health professionals and the clients in the study of medical communication that takes place (Heritage and Maynard, 2006) rather than focusing on the health professional alone in order to find ways of enhancing good practice.

For this study therefore, there are two levels of analysis: the macro and micro analysis of the discourse. On the macro level the study reveals that the ethos of HIV counselling centralises reproduction of knowledge under the tenet of information delivery and exploration of knowledge as macro activities of counselling (see Levinson, 1992; Silverman, 1997). It also demonstrates that at the micro level of interaction there are several activities happening during this reproduction of knowledge: there is a collaborative exchange of knowledge among participants either by reproducing existing knowledge (declarative knowledge) or by constructing new knowledge as questions of actual application are dealt with in the talk (procedural knowledge); there is negotiation of shared knowledge; and there is orientation to different types of knowledge sources during the interaction.

The current chapter presents an analysis of the first level, i.e., the macro discourse of HIV counselling at Khokho health centre In the subsequent chapters the micro aspects of the interaction are discussed to illustrate how the participants negotiate different types of knowledge (in Chapter 5) and how they orient to the dynamics of social and institutional structures and power within their interactions (in Chapter 6).

The macro level analysis in the current chapter is based on the health professionals' articulation of what defines counselling from interviews and during interaction with the clients, and on how the institutional documents reflect the ethos of counselling within the social and institutional structures in which they are embedded. Hence this chapter focuses on the discursive practices of the participants in the reproduction of knowledge in the area of HIV/AIDS at Khokho health centre. The analysis of the results refers to audio data, insights drawn from interviews with the clients and health professionals at the clinic, observations, HIV/AIDS counselling guidelines, job aides and HTC counsellor training manuals authored by the Ministry of Health that were obtained from the health centre.

The chapter begins with a discussion of the meaning of reproduction of knowledge in interaction, followed by a presentation of the guiding principles of HIV counselling in Malawi before outlining how participants' reproduction of knowledge about HIV was reflected in the audio-data. The chapter finishes with a summary and conclusion based on the theme of reproduction of knowledge about HIV/AIDS in this context.

4.2. Reproduction of knowledge

The health centre is a site where knowledge about HIV/AIDS is reproduced and negotiated. Most discourse is a reproduction of already existing texts whereby every instance of language use reproduces "society and culture", knowledge and beliefs (Fairclough and Wodak, 2010: 106). The health centre is a site where knowledge (i.e. medical knowledge) is reproduced (MacDonald, 2002; after Bernstein, 1996). The strategies used in reproducing knowledge entail the process of recontextualisation, whereby texts of one site enter another. Another related process – intertextuality – is presented as a specific form of recontextualisation (Fairclough, 2003; Linell, 2009; also Hodges, 2015: 45) and is relevant to the reproduction of knowledge in this context (see

Chapter 2, Section 2.5). Fairclough (1992: 39) presents two theories about discourse and text oriented discourse analysis to postulate intertextuality in discourse; according to him, there is "interdependency of the discourse practices of a society or institution: texts draw upon and transform other contemporary and historically prior texts (intertextuality)". Medical knowledge in healthcare discourse is representative of that which is reproduced through intertextuality of discourse rather than that which is constructed.

Through intertextuality, knowledge from other sites is reproduced in the HIV/AIDS talk of this context. The knowledge is reproduced from other sites such as text books, research articles, institutional handbooks, in the case of health professionals (see MacDonald, 2002), and from medical leaflets, the radio, television, billboards, community talks, interpersonal communication, *inter alia*, in the case of the clients. The notion of reproduction of knowledge is also articulated by Atkinson (1977) when he describes reproduction of medical knowledge at a medical school where he analysed interaction of medical consultant, medical students and patients at the patients' bedside. Atkinson describes bedside teaching as time when some features of clinical work are reproduced – something that is known prior to the encounter is enacted by both the students and consultants. Consequently, this chapter presents the explicit attempts by the health professionals to reproduce knowledge about HIV/AIDS with the clients, while the 'official knowledge', which they draw from health booklets, remains implicit and presupposed in these exchanges. The interactional data in this chapter present some explicit strategies, mostly on a macro level, that illustrate the reproduction of HIV/AIDS knowledge between the clients and the health professionals.

4.3. Reproduction of knowledge in HIV group counselling

The group counselling sessions in this context are a different medical encounter from the traditional sense of counselling within the ethos of therapy (e.g. Sarangi, 2010b). HIV counselling is meant to be a discussion of what is known about HIV and what action to take to prevent or manage it (Balmont and Waksberg, 2012; Silverman, 1997). As stated earlier, the sessions in the antenatal clinics were conducted in groups, in what the health professionals referred to as group counselling. In a traditional sense, group counselling is used to achieve a "therapeutic cohesiveness" and groups meet over a period of time (Paul, 2012: 617). Cohesiveness is a description of a relationship that

may develop among members in a group that is believed to be therapeutic. Group counselling, in the context of this study, was *ad hoc*, as membership depended on the number of pregnant women present. The formulation of such a group may offer different dynamics than would be considered if members of the group met more than once, as in traditional group therapy. Thus, conducting counselling with the clients in groups, as done in this context, presents a unique communicative relationship.

In order to understand the nature of this health professional-clients encounter, interviews and documents are analysed. Documents at the healthcare centre were particularly analysed in order to understand the nature of interaction that is expected during group counselling sessions and the analysis is presented in section 4.3.1 (e.g. Roberts et al., 2014).

4.3.1. HIV counselling guidelines

The guidelines on group counselling present several activities for the counsellor: he or she is the provider of information as well as the one who supports the client in exploring how best to respond to the HIV/AIDS pandemic and make an informed decision about being tested. In a study of genetic counselling Sarangi (2000: 2) observes that there is "interactional hybridity" in this activity of medical counselling. As an activity type (characterised by the setting), genetic counselling has several discourse types (form of the talk) embedded within it, *viz.* information giving, advice giving and decision making (Sarangi, 2000). Similarly, HIV counselling poses an overlap of activities as it draws from the activity of counselling but comprises the activities of information giving, information exchange (discussion), advice giving and making a decision about having a test or not (Silverman, 1997).

HIV counselling and education guidelines that were obtained in this study context specify that the counsellor has to give information to the client so 'information-giving' in this kind of counselling distinguishes this type of counselling from other types, in that the client is forthrightly expected to spend a considerable part of the session receiving some information rather than presenting his or her problems. Moreover, the clients in most cases may not have attended the sessions because of problems that they want to talk about, but attend counselling as a prerequisite to HIV testing, which may potentially render them passive. In this context of antenatal clinics, group counselling is the main activity as opposed to individual counselling. Moreover, group counselling

is more of an educational nature (Shillitoe, 1991) so that it reduces the opportunity to express personal feelings.

The printed guidelines of HIV counselling separate the group counselling protocol from the protocol for individual counselling sessions. Presented in Table 4.1 is an excerpt from the HTC protocol booklet (MOH, 2013: 7) that counsellors are to follow for group pre-test counselling. The booklet was kept handy on the counsellors' desk for reference whenever required. Focus has been given to Steps 1 to 4 which are quoted in their entirety here because they contain the main component of the pre-testing session which constituted data for the analysis.

Table 4.1: Extract of HTC Protocol

Step 1: Introduction to group education
Step 2: Basic information on HIV and AIDS • Explain that HIV is a common problem in the country • Discuss the difference between HIV and AIDS • Discuss modes of transmission • Discuss HIV prevention strategies, including: condom use, faithfulness, abstinence, VMC, PMTCT and ART including PEP • Discuss relationship between HIV and STIs/TB • Discuss the importance of testing for pregnant women
Step 3: Benefits of HTC • HTC provides access to prevention, treatment, care and other support services • HTC helps the client to plan for the future
Step 4: HTC session overview • Explain that HTC may be accessed as an individual, couple or family – in addition, a caregiver might accompany a child • Explain confidentiality • Explain that HIV testing is done using a few drops of blood from a finger prick • Outline possible HIV test results (negative, positive, indeterminate) • Explain that post-test counselling is based on test outcome (positive, negative, inconclusive) • Discuss common risk issues and concerns • Provide estimated duration of 1-to-1 session • Give time for questions and clarify any general issues • Defer personal issues for the 1-to-1 session
Step 5: Offer HIV test…
Step 6: Test procedures…
Step 7: Test results …

The choice of verbs in the guidelines, presented in Table 4.1, hints at mixed approaches in the talk, in that some verbs indicate unidirectional talk, for instance the verb ‘explain’ is setting up the expert position of the health professional, while the verb ‘discuss’ is

more dominant in Step 2 and emphasises collaboration. The verb 'discuss' may imply a two-way involvement between client and health professional in sharing basic information about HIV/AIDS. The choice of diction "discuss" presupposes the existence of knowledge for both participants prior to the interactions and suggests an egalitarian relationship between client and health professional. By using the term "discuss", this text constructs agency on both the clients and health professionals, but on the other hand the existence of the verb "explain" on one of the guidelines in Step 2, implies that a level of dominance by the health professional is possible (Martin, 2000). In some cases it was recognised that there is information that is expected to be explained to the client, for instance, test procedures or existing support services, because such information is limited to the health professional as an expert (Steps 1 and 4). In this regard, basic information about HIV/AIDS (in Step 2) is considered to be a matter for discussion.

Furthermore, the counselling sessions are meant to be client focused as the counsellors' training manual encourages that "the counselling session should be fluid and follow the direction that the client wants to go" (MOH, 2007: 98). The health professionals are encouraged to follow general principles of counselling, some of which are stated in HIV Testing and Counselling Training Manual (MOH, 2007: 85) and quoted in Table 4.2.

Table 4.2: Extract of HIV testing and counselling training manual

The following are some guidelines you can make use of

- be interested in the client as a person
- help people to talk about their feelings
- do not moralise, preach or patronise
- do not encourage dependence on the counsellor by making yourself more important than is necessary.
- do not interrogate

Ministry of Health, *HIV testing and counselling training manual* p. 85

The statements from the manual in Table 4.2 are an indication that the health professional and client should explore the issues together. It is not entirely the task of a counsellor to present information. There is recognition that the client has a contribution to make in the flow of the talk, although they may be positioned as recipients of information. The counselling guide suggests multiple roles for the health

professional, such as “giving general information about HIV and confirming that the clients have a base-level of knowledge about the virus” (p. 99, MOH, 2007, HIV testing and counselling: Counsellors training manual). The latter, on confirmation of knowledge, suggests that this level of talk is based on the assumption that prior knowledge exists.

Presentation of information is a focus of HIV counselling during which the counsellor leads the session while ensuring that the client has knowledge about HIV. On the other hand, the activities are based on the tenets of general counselling whereby the clients have to talk about their feelings while being less dependent on the counsellor. The guidelines also present the opportunity to share concerns that the clients have, as they state “Counselling and testing is considered an opportunity for clients to [tear] down walls of silence … in removing stigma, and a tool for behaviour change” (p. iii HIV Counselling and Testing Guidelines for Malawi). This provides a forum for the clients to speak out and ask questions and potentially enables the participants to attach meaning to what they have heard and learnt before. Based on this background it is believed that the guidelines uphold a collaborative reproduction of knowledge during the interaction. But at the same time they present a challenge to the health professionals, which is reflected in how they negotiate the dichotomy of their own role in information giving, and that of the clients whose perspectives are considered central in the discourse (Peräkylä and Silverman, 1991; Silverman, 1997).

The clients at the health centre usually have prior knowledge about HIV that they obtain from other information sources and their experiences, which they bring to the health centre as they interact with the counsellors and other health professionals (Chasi and de Wet, 2006). There has been a widespread awareness of official information about HIV/AIDS (Kunkeyani, 2013; NSO, 2010; Pakachere, 2010). Interviews with the clients revealed that the clients have had information from the radio, outdoor health promotional messages, oral talks and door to door visits by health workers, and they bring some knowledge of this to the healthcare centre as they attend antenatal services. Such prior knowledge, as professed by clients, presupposes the potential to contribute to the interaction where they can either respond to the questions or make comments.

Similarly, conversation with the health professionals revealed that they operate with an awareness that clients already have a lot of information because of public health activities that are prevalent on the theme of HIV and AIDS. This gives me an

assumption that, together with the health professionals, the clients can reproduce knowledge that would compel them to proceed to be tested and follow any course of action according to the results of the test.

The topics that are covered during group counselling and education sessions in the antenatal clinics are referred to as 'basic' in the guidelines. The following quotation from the HIV counsellors' guidelines spells out the topics that are to be covered in the sessions. The health professional is required to give "basic information" of mother to child HIV transmission which is stated as follows:

> HIV vs AIDS, transmission, prevention strategies, PMTCT (Prevention of Mother to child transmission), delivery in a health facility, nutrition, family planning, couple HIV testing and counselling, infant testing. (And) For HIV testing process: HIV testing procedure, possible results, and implication of positive and negative results, ask clients to proceed to HTC.
>
> Ministry of Health, *HIV Counselling Guidelines*, 2013

Added to the list in the quotation are two topics: syphilis and male circumcision (for reduction of HIV transmission and prevention of cervical cancer for women). The health professionals stated during the sessions that the two topics are a recent addition by the Ministry of Health to the relevant areas to be covered during the sessions. Listed in Table 4.3 are the topics that were discussed in the sessions according to different health professionals and in the different sessions.

Table 4.3 Topics covered in the group sessions by different health professionals

Topic	HP1 (S 1)	HP1 (S 2)	HP2 (S 3)	HP3 (S 4)	HP4 (S 5)	HP4 (S 6)	HP5 (S 7)
Meaning of HIV and AIDS			x		x	x	
HIV Transmission	x		x		x	x	x
HIV Prevention strategies	x	x	x	x	x	x	x
Importance of HIV test during pregnancy	x	x	x	x	x	x	x
Mother to child HIV transmission	x	x	x	x	x	x	x
Prevention of mother to child HIV transmission	x	x	x	x	x	x	x
Nutrition and breastfeeding	x	x					x
Syphilis, dangers to pregnant women	x				x	x	
Male circumcision: for prevention of cervical cancer and reducing HIV transmission					x		
TB, symptoms and treatment					x		
Male involvement in HIV testing	x	x	x	x	x		
Family planning/ contraception	x			x			
HIV test and procedure	x		x		x	x	x

Key: HP: Health professional

S: session

X: Indicating topic covered in a session

Table 4.3 indicates the topics that different health professionals covered in their talk and it is observed that they followed topics stated in the guidelines but with a variation in areas of emphasis. The health professionals followed this selection of topics in varied ways, some tackled almost all the topics, while some focused on just a few: for instance, HP4 in Session 5 covered a longer list of the topics compared to the rest of the health professionals, he skipped only 2 out of the 13 topics. In one of the talks HP4 opened with a structure of the session in which he listed all the five topics he was to cover and he managed to cover them all. Another practitioner, HP1 in Session 1, also covered most of the topics, up to 10 out of the 13, where she emphasised prevention strategies

for mother to child transmission with more focus on safe breastfeeding practices for women with HIV positive serostatus. Another practitioner, HP3, covered 6 out the 13 topics and spent a significant time on a few, namely prevention strategies, condom use, and male involvement in HIV prevention. Time spent on each topic also varied across health professionals, for instance, HP1 spent about one third of her talk, in session 1, on the topic of transmission of mother to child and skipped the section of meaning of HIV and general transmission, a section that was addressed at length by HP2 and partly by HP4.

The variation in the choice and emphasis of topics is one way that the health professionals demonstrated differences in their interactional practices. While they all followed institutional guidelines in terms of the topics that they covered, they did so in varied ways, with some adhering to the guidelines more than others, for example HP4 in Session 5 covered all but one topic, while HP1 in Session 2 covered 6 out of the 13 topics. The variability in choice and emphasis given to topics was also observed between sessions conducted by a single health professional (e.g. HP4 in Sessions 5 and 6; and HP1 in Sessions 1 and 2). These variations in healthcare interaction are expected because the encounter is a complex interaction of variable systems not only of specialities, and knowledge but of "communicative expertise" as well (Sarangi, 2010b: 168). The variations in handling the sessions may also be due to differentials in health professionals' experience and expertise (Sarangi and Gilstad, 2014), for instance HP1 with eight years' experience chose fewer topics to emphasise than HP4 who had served for about six months and attempted to cover most of the topics. Sometimes the environmental context in which there were more women seated beyond the capacity of the counselling room with soaring temperatures, according to my observation, necessitated a reduction of topics and duration of sessions (e.g. Session 6 by HP4, see field notes in Appendix 10). More aspects of variations are shown across the interactional data and are revealed further in the analysis, especially in Chapters 5 and 6.

The interactional data collected for this study are used to examine the discursive practices of the clients and the counsellors. The data indicate that the health professionals tried to involve the women in the talk while the knowledge from the Ministry of Health documents is recontextualised in the counselling sessions. They worked on jointly reproducing their knowledge with the women rather than didactically

presenting the information. Section 4.3.2 provides health professionals' and clients' views on the interaction during HIV counselling.

4.3.2 Reference to interviews with health professionals and observation data

In the interviews, the health professionals talk about the need to "discuss" rather than simply talk to the clients during counselling, and "reminding one another" about HIV/AIDS with the clients, rather than giving information about HIV unilaterally. Their reflections have implications for the nature of the talk as they expect the counselling session to be a participatory one. Four of the health professionals believe that the clients have knowledge about HIV/AIDS because there is a lot of information about HIV/AIDS disseminated in the villages, such that the counsellors do not have to explain much during the talk. In this case the health professionals refer to what is in the protocol, where "discussing" is granted prominence during Step 2 (basic information on HIV/AIDS, see Table 4.1) rather than simply giving the clients basic information about HIV/AIDS.

The health professionals' preferred nature of interaction with the clients was highlighted during the interviews. They describe ideal counselling sessions as those that are in the form of discussion forums, rather than having a unidirectional flow of information whereby the health professionals act as presenters. The quotes (Examples 4.1 and 4.2) below are selected from the interviews that were conducted with the health professionals in which they respond to questions about their perceptions of the interaction with the clients during counselling and clients' knowledge about HIV (see Appendix 5 and 11). These interviews were conducted at different times following the group counselling sessions. Knowing that interview data is co-constructed with participants (Mann, 2011, 2016), I tried as much as possible to avoid comments which could lead the participants to say something differently during the interviews. I mainly gave affirmative feedback, such as "mmh" to indicate that I was following them and "okay" especially where they used tag questions such as "right?" or expected my response. I hope that this way the participants' views on the issues are prominent while my voice as a researcher is minimised.

All interviews are presented in the original language, Chichewa, followed by English translation. The health professionals are represented by 'HP', the women by 'W', while

'R' represents me as an interviewer. Transcript conventions for these extracts are presented in Appendix 1.

Example 4.1: Health professionals' views on counselling as an interaction

A female health professional (HP1) responds to the question on her perceptions of interaction with clients. The interviews were conducted at the end of one of the group counselling session after closing the HTC centre.

1	R:	*Kodi kwa inuyo kulumukizana kwabwino pakati pa inu ndi client*
		How would you describe an ideal interaction
2		*Popereka uphungu ndikotani?*
		between you and the clients during counselling?
3	HP1:	*Kuti counselling iyende bwino client uja amayenera kuti*
		For counselling to be successful the client is supposed to
4		*iyeyo ndi amene akuyankhula kwambiri kuposa ndani?*
		speak more than who? the counsellor right? (.)
5		*Khansala eti (.)*
		the counsellor right? (.)
6	R:	*Mmm*
		Mmh
7		*Iyeyo akhale kuti akukupatsa information yambiri (.)*
		He or she is supposed to give you more information
8		*chifukwa zambiri umayenera uzitenge kuchoka kwandani*
		because the counsellor has to get the information from who?
9		*kwa iye uja, client uja:: (.)*
		him or her, the client:: (.)
10	R:	*Owoo*
		Okay
11	HP1:	*Iye akhale kuti akupereka information yambiri*
		He or she is supposed to give you more information
12		for counselling to be successful.

Example 4.2: Health professionals' views on counselling as an interaction

A male health professional (HP5) responds to the question on his perceptions of interaction with clients. The interview was held in the HTC room after an antenatal group counselling session. This time the HTC was closed for the day.

1	R:	*Kodi kwa inuyo kulumukizana kwabwino pakati pa inu ndi client*
		How would you describe an ideal interaction
2		*Popereka uphungu ndikotani?*
		between you and the clients during counselling?
3	HP5:	*Counsellingtu:: siifunika uyankhure zambiri (.)*
		Counselling:: does not require one to speak a lot (.)
4	R:	*Mmm:↑*
		Mmh:↑
5	HP5:	*koma kufunsa mafunso iwowo adziyankha (.)*
		but to ask questions and they should answer (.)
6		*Client ndi amene amachita lead session (.)*
		The client is the one who leads the session (.)
7		*kwa ife kumangokhala kuchita probe.*
		Our duty is simply to probe
8	R:	Owoo
		Okay

In both Examples 4.1. and 4.2, the health professionals construct themselves as facilitators of an information sharing process; their task is just to "probe" (Example 4.2, line 7) as the clients share what they know. HP5 states that the client is the one who leads the session. They present counselling as a collaborative task where sharing of information is not meant to be unidirectional.

In Example 4.1, HP1 states that the client should be the one to give more "information" than the health professional, she states that "*iyeyo akhale akupereka* information *yambiri"* (he or she is the one to give more information, line 7). So HP1 presents the idea of collaboratively reproducing knowledge about HIV/AIDS with the clients as being what counselling is about. She expects that both her and the clients should share information which culminates into a joint construction of meaning and interpretations (knowledge). Moreover, this nature of HIV counselling where the clients are assumed

to already have the basic knowledge about HIV/AIDS presents a noteworthy angle in the analysis of the talk. Examples 4.3 and 4.4 illustrate health professionals' views of the level of clients' knowledge.

Example 4.3: Health professionals' perceptions of clients' level of knowledge

A female health professional (HP1) responds to the question on clients' level of knowledge. This was a continuation of interview in Example 4.1.

1	R:	*Kodi mukuwona kuti chidziwitso cha ma client chokhudza makhwala*
		How would you describe the clients' level of knowledge
2		*Ndi kudzisamala pa nkhani ya HIV/AIDS chili bwanji?*
		about HIV/AIDS treatment and management?
3	HP5:	*Masiku ano anthu ali ndi chidziwitso olo ukamafunsa kuti*
		These days people have the knowledge, even if you ask them
4		*>HIV ndi chani?< umaona mmene akuyankhira.*
		>What is HIV?< You actually see the way they are responding
5		*Anthu akudziwa (.) sitimachita kuchulutsa (.)*
		People know (.) we don't say much (.)
6	R:	*Owoo*
		Okay
7	HP5	*timangodutsa mfundo zikulu zokhazokha*
		you just focus on the main aspects (.)
8		*Sizofunika kulongosora zambiri (.)*
		it is not necessary to go on to explain everything (.)
9		*Counselling imakoma anthu aja ukawalora kuti adziyankhura (.)*
		The counselling is exciting when you let them talk (.)
10	R:	*Mmm ↑*
		Mmh ↑
11	HP5:	*Ukamangoyankhura wekha anthu aja amaboweka (.)*
		When you are the only one talking the clients get bored (.)
12		*komanso akamayankhula iweyo umaphunziranso zambiri.*
		and when they are talking that way you also learn a lot from them .

Example 4.4: Health professionals' views on clients' participation

A male health professional (HP6) responds to the question on clients' level of knowledge. This interview was conducted at the end of one group counselling session, this was after a lunch break when the HTC was closed for the day.

1	R:	*Kodi maganizo anu ndiotani okhudza mbali yomwe*
		What is your opinion on the nature
2		*amatenga ma client pamene mukulumikizana muuphungu*
		of client participation during counselling
3	HP6:	*Chimachitika ndi chakuti:: anthu aja akamabwera (.)*
		What happens is:: as the clients come (.)
4		*amakhala kuti chisankho achipangira kwawo konko::*
		they have already made a decision right in their homes::
5		*kubwera kunoko (.)*
		that they are coming here (.)
6	R:	Mmm
		Mmh
7	HP6:	therefore *china chilichonse chingachitike pamenepo (.)*
		therefore whatever happens here (.)
8		*chimakhala chosavuta (.)*
		is easy for they are ready (.)
9		*timakambirana ndithu bwinobwino kwambiri*
		and we discuss very well
10		*ndipo amapezeka sakubisa information ili yonse (.)*
		and they do not hide any information (.)
11		*kumangokhala kukambirana.*
		it simply becomes a discussion

In Examples 4.3 and 4.4, the health professionals recognise that prior to the consultations the clients already have basic knowledge about HIV/AIDS as they come to the health centre. HP1 in example 4.3 believes that "people (the clients) know" (line 5). She uses the terms "*akudziwa"* (they know) and "*chidziwitso*" (knowledge) in reference to the clients' capacity. Despite this recognition that the clients have knowledge about HIV some of the health professionals still take the clients through all the stages of the talk, from explaining basic information about HIV to the testing stage. Their talk includes asking basic questions such as "What is HIV?" (cf. Example 4.8) which may not always be necessary, given the clients' knowledge. It is observed that starting the talk from the stage of very basic information is done by some of the health professionals to strictly follow the required protocol, while others varied the sessions by excluding such basic topics and going straight into the descriptive topics (see Table 4.3).

The health professionals expect the clients to provide answers to the health professionals' questions and share what they know. They expect the clients to lead the discussion. The extent to which the clients can "lead" (see example 4.2, line 6) the counselling is a matter that will be discussed in the analysis of the actual interaction (e.g. Examples 4.8 and 4.9) in this chapter. According to these interview extracts, the health professionals realise that by letting the clients "lead" and share much of what they know, the health professional "learns a lot" in the process. In this case HP1 and HP6 present the client as having some knowledge to bring to the interaction, therefore they are capable of participating in a knowledge exchange with the health professionals. Therefore, the health professionals construct counselling as a forum for collaborative reproduction of knowledge. They indicated that the client has knowledge to share and the health professionals may build on that knowledge for a meaningful talk. The engagement of the participants within the distinct knowledge systems reveals that there are complexities shaped by wider macro contexts whereby authorised and other forms of knowledge (e.g. local and cultural) are sometimes in tension (e.g. Fairclough, 1992; Higgins, 2014) or their synthesis is negotiated (Canagarajah, 2002). The extent to which the synthesis of knowledge between health professionals' and clients' knowledge that is alluded to in these interviews will be examined in Chapter 5, and how these result in a tension influenced by social and institutional structures is covered in Chapter 6. The clients' views on the counselling sessions were also sought and are presented in Section 4.3.3.

4.3.3 Reference to clients' views about the interaction

The women at the antenatal clinic were interviewed after the group counselling sessions to grasp their perception of the interaction during the counselling process (see Appendix 4 and 12). From these interviews the clients' sense of the information sharing process in relation to their own prior knowledge about HIV was obtained. It was important to obtain the clients' sense making from the interviews because interviews provide insights into the clients' construction of their own role as participants in the discourse (Doherty and Saunders, 2013).

When asked to give their views on the interaction, most of the women shared positive feelings about the interaction responding that "*inali bwino"* ("it was okay") and that they had learnt a lot. The interview included a question that required them to share their reaction to the interaction and how they had opportunities to participate in the interaction. In their responses there were a number of references to prior knowledge, rather than what was learnt during the current interaction. Most of the women view the counselling sessions as opportunities to learn, "to remind one another" (and to be reminded) of prevention and management of HIV/AIDS. One woman described the process as a learning situation, "… I have learnt a lot, they have taught a lot that we did not know." (W7). The use of 'taught' here implies that she views the interaction as an expert and client situation whereby learning, on her part, had taken place. When asked to specify exactly what new things she learnt, her response indicated that among all the information that was shared there was something new that added to her knowledge namely "how the baby contracts the virus from the mother, and how the baby can be protected, on that I feel that I have learnt something" (W7).

Although admitting prior knowledge due to exposure to information at the clinic and various media around their homes, the women admitted that the counselling sessions were still helpful. Even though most of them emphasised that they already knew most of what was shared about HIV during the counselling they also pointed to the interaction as an opportunity to reinforce knowledge. The following quotes, (Examples 4.5, 4.6 and 4.7), illustrate the women's views about the sessions. As mentioned earlier in Chapter 3, interviews with clients were not audio recorded but I recorded them in writing, therefore they are not in transcript form. I recorded the women's responses on a sheet of paper where I had a list of the key questions (see appendix 12). I tried to maintain a conversational format of interviewing as much as possible, for instance some comments

that were digressions from the core questions were not written down immediately. But I took time immediately after the interviews to fill in my notes and make note of anything that I learnt from those extra responses from the women. Therefore, although the interviews were not audio recorded, I tried to write verbatim as the women were responding to the key questions and their views are presented in Examples 4.5, 4.6, and 4.7.

Example 4.5: Women's views of the counselling sessions

W2: *Ine ndimadziwa kale zambiri, anenazo ndinamva kale. Ndaphunzira za momwe ungapewere matenda kwa mwana. Koma zambirizi ndinamvapo ndimadziwa. Ndinangolimbikitsika basi*

I already knew a lot, most of what was said is what I heard before. I have learnt how one can protect the baby from the disease. But most of what was stated is what I knew before. It was just about being encouraged.

Example 4.6: Women's views of the counselling sessions

W3: *Koma osati kuti amanena chachilendo chilichonse zambiri amanena iwo ndimazidziwa. Timazimva. Apa tinali ndi mwayi oti tifunse mafunso ndipo atilongosorere*

But it is not like they said anything new, most of what was said I already knew. I hear about these things already, here we had a chance to ask questions and for them to explain.

Example 4.7: Women's views of the counselling sessions

W5: *Ndaphunzirapo ndithu zatsopano, ngati kukumbutsira choncho. Koma kunena zoona panalibepo chenicheni chatsopano. Zonse ndimazidziwa, kwinako kumangokhala kukumbutsana chabe. Zambiri ndimazimva.*

I have learnt something, more like a reminder. To say the truth there was nothing really new. I already know everything, this was simply about reminding one another. I already hear a lot about this.

From the interviews some women indicated that they learnt new things concerning HIV but when asked further what they learnt, they referred to what they already knew. This means that to most of the women, counselling is not about obtaining new information, it is a time to be reminded of what they already know. They had the basic knowledge but the forum created a chance to exchange information, added to the existing knowledge, and for some, it simply refreshed their knowledge. There was much reference to knowing. In Example 4.5 the client emphasises prior knowledge of what was discussed "I already knew a lot…" and "I knew before"; in Example 4.6 another said *"*what was said I already knew" and "I already know everything" in Example 4.7. During these interviews the clients indicated that the source of their original knowledge is the radio, the hospital, community health outreaches conducted by health related agencies, such as Hunger Project (an organisation operating in the villages around the health centre and whose outreach activities were mentioned by most clients and as a knowledge source), and interpersonal communication. This prior information that the clients have may mean that collaborative reproduction of knowledge, rather than health professionals alone simply delivering information to the women, is a possible format that the group counselling may take.

The women's revelation of having prior knowledge at the same time as having learned something new means that the client and the health professionals may have the potential to jointly reproduce knowledge and construct shared meaning during the talk. The client who knows something, in this case about HIV, is expected to be agentive and take a proactive role in the interaction (Moore, 2005); he or she is expected to ask questions and sometimes "lead the discussion" according to his or her needs. Knowledge is expected to be reproduced by both the health professionals and the clients alike, although their knowledge sources may differ, for instance, the health professionals relate to medical knowledge and the client bringing in personal experience (Richards and Lussier, 2014). In Section 4.4, the issues raised in the interview data above are related to interactional data in order to explicate the extent to which the participants reproduced their professed knowledge about HIV. More quotations from the interview data are used to support the analysis of the group counselling interactional data throughout the thesis.

4.4 Participants' reproduction of knowledge during interaction

The interaction of health professionals and clients was analysed in terms of contributions that the participants made to the discourse. Two data extracts below present how both the clients and the health professionals attempted to collaborate in the talk.

4.4.1 Health professionals explicitly encouraging women's contributions

The health professionals utilised implicit and explicit strategies to engage the women to share what they know about HIV/AIDS. The health professionals led the discussion and encouraged the women to contribute in accordance with their knowledge. Example 4.8 illustrates how the health professional explicitly presents the women as co-presenters of information with him. Example 4.8 is from a counselling session by a male counsellor (HP4) to a group of 15 women seeking antenatal services. This talk is held before an HIV test is conducted and this is at the beginning of the talk. Transcript conventions for all the excerpts are provided in Appendix 1.

Example 4.8: Interaction between counsellor and pregnant women

Context: HP4, a male counsellor, at the opening of his talk to a group of 15 pregnant women. This talk is held before an HIV test is conducted. W represents several or all women speaking at the same time, while codes W1, W2 etc. refer to individual women in this example.

1	*HP4:*	*Kuli bwino tingogwiritsa* fifteen minutes *pokambirana*
	HP4:	So it is better to just use fifteen minutes to discuss as a group
2		*kuti timvetsetsane (.)*
		so that we understand really well (.)
3		*kenako tidzayezane magazi, eti?*
		then we will conduct blood tests, right?
4	*W:*	*mmm*
	W:	Mmh
5	*HP4:*	*Kotero kuti mukhale omasuka (.)*
	HP4:	In that case, be free (.)
6		*ine siwozindikira, awo siwozindikira (.)*
		I am not knowledgeable, that one is not knowledgeable (.)
7		*m m komanso inu ndinu anthu ozindikira (.)*
		er and you are knowledgeable (.)
8		*zomwe mutatipatse inuyo, ifeyo, awowo,*
		the ideas that you, us, they, give us,
9		*tonse kuchita chinthu (.)*
		all of us doing something (.)
10		*tonse tichita chinthu chanzeru eti?*
		it means we will produce something sensible right?
11	*W:*	*((ena)) Mmm*
	W:	((a few)) Mmh
12	*HP4:*	*Inu mmaona kuti HIV ndi chani (5)*
	HP4:	According to your understanding, what is HIV? (5)
13		*Kuyankhatu pamenepo mafu::nso (.)sikusukulutu*
		Please respond to the questio::ns (.) this is not a school setting
14		*koti ukangoti (.) CHAKUTI*
		where you have to accurately say (.) THIS
15	*W:*	*((ena)) mh he he*

	W:	((some)) Mh heh heh
16	*HP4:*	*HIV?*
	HP4:	HIV?
17	*W1:*	*HIV ndi kachilombo koyambitsa Edzi*
	W1:	HIV is a virus that causes AIDS.
18	*HP4:*	*EYA, mukamayankha chonchotu tichoka mwachangutu*
	HP4:	YES, when you respond like that we'll finish within a short time
19		*HIV ndi kachilombo koyambitsa (.) matenda a Edzi eti?*
		HIV is a virus that causes the disease (.) AIDS, right?
20	*W:*	*mmm*
	W:	Mmh
21	HP4:	*Mat- Edzi ndi matenda mmene mwaneneramo*
	HP4:	Dis- AIDS is a disease as you have put it,
22		*nanga si mwamalizitsa, eti?*
		you said it all, right?
23	W:	Mmm
	W:	Mmh
24	*HP4:*	*Kachilombo kameneka timakatenga bwanji? (.) Ee inu.*
	HP4:	How do we contract this virus? (.) Yes, you.
25	*W2:*	*Kubwerekana malezara*
	W2:	When sharing razor blades
26	*HP4:*	*Kubwerekana malezara, <u>ee</u> <njira yoyamba imeneyo> yachiwiri?*
	HP4:	Sharing razor blades, yes, <that is the first way> the second one?
27	*W3:*	*Kugonana*
	W3:	Sex
28	*HP4:*	*Kugonana?*
	HP4:	Sex?
29	*W3:*	*Mmm*
	W3:	Mmh
30	*HP4:*	*Yes, ndi inu eti?*
	HP4:	It's you right?
31	W3:	*Mm*
	W3:	Mmh
32	HP4:	*Mwanena <u>ndi inu</u> eti?*
	HP4:	<u>You</u> are the one who has mentioned that, right?

33	W3:	*Mmm*
	W3:	Mmh
34	*HP4:*	*Kugona:na. Ina?*
	HP4:	Se:x. Another one?
35	*W4:*	*Majakisoni.*
	W4:	Injections
36	*HP4:*	*Majakisoni >nde malezala amenewo<,*
	HP4:	Injections >that is sharing razor blades<,
37		*kaya pangozi, majakisoni eti?*
		whether during accidents, injections right?
38		*Koma tinene kuti kugonana mosadziteteza (.)*
		But let us say having unprotected sex (.)
39		*ndi munthu amene (.) sitikudziwa kuti magazi ake ndiwotani, eti?*
		with a person (.) whose blood status we do not know, right?
40	*W:*	*Mmm*
	W:	Mmh

The health professional (HP4) opens the discussion (in Example 4.8) by setting the agenda of the talk (lines 1 to 3), stating that they are meant to 'discuss', to 'understand one another' before they conduct the blood test. By formally mentioning that they have to "discuss as a group" (line 1) the health professional clearly invites the women to jointly reproduce their knowledge with him. The health professional uses the term "discuss", as presented in the HTC guidelines, to call for the women's participation in the group talk.

Apart from introducing the mode of the talk, he also mentions the duration of the talk, (in line 1) "it is better to just use fifteen minutes" this way he justifies the format of the counselling which in the case of antenatal consultations is largely done in groups rather than a one-to-one interaction. I observed that the women were tired after long procedures at the antenatal clinic and they had listened to another educational talk conducted by a nurse prior to the current counselling session. Hence the counsellor's emphasis of duration may justify the group format of the talk to the women. Contextually, his statement alludes to the need for the women to fulfil the requirement of attending counselling before the test. His statement serves to encourage the women that discussing as a group, rather than one-to-one, was time saving. The women affirm his arrangement by responding positively in line 4. Presenting the agenda of the talk

was important for the women to understand the goal of the session and share an understanding on the duration of the talk, which indicates a direction towards a collaborative talk; although the women's response to HP4's statement is minimal (line 4) it provides an encouragement for the health professional to proceed with the talk.

In the lines that follow, the health professional positions the women as knowledgeable and having some understanding which, together with him, could assist in the direction of the talk (lines 6 and 7). Although this may work as a rhetorical strategy on the part of the health professional to achieve client-centredness (Roberts and Sarangi, 2005), it shows how the health professionals frame their talk in relation to the clients. HP4 explicitly encourages the women (in lines 5 to 10) to contribute their knowledge. He acknowledges them as experts, and he rhetorically denounces his expertise and upholds the women as experts who have something to contribute to the talk. He emphasises the women's expertise and encourages the need for acting as a group (lines 5 to 7), "I am not knowledgeable" (talking about himself) "that one is not knowledgeable" (referring to another person within the group) and "you are knowledgeable" (to the group of women more generally). With such statements he indicates that the sessions are not an individual effort but they are to reproduce their knowledge together as a group. According to his statement, "all of us doing something (.) it means will produce something sensible" (in lines 9 to 10) he constructs the group's role. That as a group, they will produce something more "sensible" than what individual participants can each produce, which is a direct call to collaborate with the women.

HP4's explicit statement is in line with the aims of group counselling, where a "synergy" – a notion that members have a potential to develop more when in a group than when they are alone – develops in a therapeutic group (Paul, 2012: 619). As a result of that explicit call to the women, the responses they give to HP4's questions illustrate how they were encouraged to share their basic knowledge about HIV (lines 17-30). The women give him the answers to his questions in quick succession. HP4 also seems encouraged by the women's answers and admits it (line 18) where he states that by responding the way W1 did (in line 17) they would finish the session earlier.

The first question of the health professional on the meaning of HIV in line 12 and repeated in line 17 seems to check the women's knowledge. However, the question is not immediately responded to, as seen by the five second pause after line 12, after which HP4 repeats his encouragement to make the women respond to the question. He seems

to know that the women have an answer to the basic question but may not feel free to speak up, and he downplays their fears by stating how any answers will be accepted (line 14). In the rest of the interaction the women easily respond to his questions and enact the 'knowledgeability' that he had attributed to them. One of the women reflects her knowledge as she defines the meaning of HIV (line 17) to which HP4 emphatically says "YES" (line 21) to affirm the answer, and proceeds to reiterate how such responses are essential to the talk. By pointing to the importance of the women's answers to the talk he also positions the women as the ones to "lead" the talk, thereby suggesting that collaborative reproduction of knowledge would speed up the session. His positioning of the women as leaders of the talk may nevertheless be different from what is actually happening in the interaction; by asking questions he is in control, although he aims at collaborating with them (Ribeiro, 1996). There are some ambiguities in the use of question and answer forms which are examined in detail in Chapter 6.

The health professional (HP4) in Example 4.8 has used several linguistic strategies to collaborate with the women as group. There is frequent use of collective pronouns 'us' and 'we' throughout the excerpt, that seems to be more inclusive of himself and the women as a group. In Chichewa "we" is reflected in the use of prefix *ti-* attached to words to indicate the subject position. In one of his statements (lines 1-3) there is a distinction in the use of "we" which is indicated by the prefix *ti-*, he is using the same "we" (prefix *ti-)* but creating two in-groups. There are two different referents to the pronoun 'we' in one statement, the first one is where he uses pronouns that are all inclusive, *kuti* ***ti****mvetsetsane* ("so that **we** understand really well"), and the second one is where he sets himself as part of a medical group, "*kenako* ***ti****dzayezane*" ("then **we** will conduct blood tests") (line 3). In the latter he uses "we" to align himself with the medical group while in the former, "we" is used to align himself with the women. Such a multidimensional use of pronouns illustrates the dilemma that he could face as an expert trying to align himself with the women and the institution at the same time leading to enactment of two identities (Roberts and Sarangi, 2005).

Use of collective pronouns "we"/"us" to construct oneness with the women is common in his talk; for instance when he asks the question, "how do we contract this virus?" (line 24) he aligns himself with the women, although there is no indication anywhere in the talk (nor from conversations with me) that he is HIV positive. Similarly, when he says "But let us say having unprotected sex… " (line 38) by using "us" he reflects the idea that he is in this action together with the women.

It is observed that gender differences between HP4 and the women did not distinguish the strategies of collaboration with those used by female health professionals (e.g. HP3 in Example 4.8 and HP1 presented in the subsequent chapters). Although the health professional in the quoted example (4.8) is a man interacting with a group of women he frequently uses the pronouns of collectiveness as stated above. Later in the interaction (after the extract in Example 4.8) he tells the women:

> *...Komanso panthawi yomwe tikuyamwitsa(.) sinchoncho? zitha kutheka kuti pamene tikuyamwitsa mwana (.) mabere athu ali ndi zilonda…*
>
> …Also at the time we are breastfeeding (.) right? It may happen that at the time of breastfeeding the baby (.) our breasts have sores…

In the statement above he liberally uses the collective pronouns "we" (prefix ti- for Chichewa) to align himself with women, although he is a man, to the point that it sounds odd when he talks about sores "on our breasts". In this case it was observed that despite being a man he attempts to overlook gender differences existing between the health professional and the women.

There are also instances when HP4 uses a different pronoun, "you", for example "as you have said" (line 21), to present ownership of the statement to the woman who raises a point rather than attributing it to himself or the group. He repeats the subject pronoun "you" in line 22 to position the woman who gave him the answer to his question as the owner of the information rather than himself. By doing that he portrays client centredness as he transfers agency of this given information to the woman (e.g. Staples, 2015). The use of the pronoun "you" is discussed further in Example 4.9 in section 4.4.2.

Another strategy that the health professional (HP4) uses to ensure that they are all involved in this reproduction of knowledge is repetition of the women's responses to reinforce their points. For example, the health professional repeats the woman's (W1) response, as "AIDS is a disease as you have put it, you said it all, right?" (lines 21-22) and the woman agrees in line 23 and he repeats this referent in line 32 "you are the one who has mentioned that, right" again the woman (W3) affirms in line 33. When the woman confirms that it is she who responded, he repeats her answer (line 34) before

asking the next question. By repeating the woman's answer, "sex" (line 34), he seems to confirm that it is the right response and attributes ownership to the women. This is a strategy which exhibits a collaborative reproduction of knowledge by the women alongside the health professional.

In the interaction above (Example 4.8), HP4 displays features which are also applied in classroom discourse. By using the question and answer format, he elicits information from the women, thereby enabling them to reproduce their knowledge; on the other hand, it presents an asymmetry of roles between them because by asking questions HP4 places himself in control (Walsh, 2011). The question and answer form is what in classroom discourse is described as an IRF (Initiate, Respond, Feedback) exchange structure; the teacher asks questions to initiate a talk, students respond and the teacher gives them evaluative feedback (Walsh, 2011; originally by Sinclair and Coulthard, 1975). Asking questions is one strategy HP4 uses to facilitate the discussion and ensure participation of the women in defining HIV/AIDS.

The quick succession of question and answer forms in lines 21 to 38 of Example 4.8 demonstrates that the women had basic information about causes and prevention of HIV prior to the talk. HP4 uses the women's answers to the questions to develop his talk by simply adding some more information where it was necessary to do so (from lines 21 to 38). For instance when one woman provides an answer to the question of ways of contracting HIV as "injections" (in line 35), as a form of feedback, HP4 repeats the woman's answer and extends this information further by saying, "…that is sharing razor blades, whether during accidents..." (lines 36-37). Immediately following this statement he adds, "but let us say having unprotected sex with a person whose blood status we do not know" (in line 42). This statement is an extension of the brief answer that one of the women previously gives in line 30. In this interaction the health professional uses the women's responses to share some more information. It is a way of showing togetherness in the reproduction of this piece of knowledge on the importance of testing, and HP4 recognises the importance of having a consensus (Barton, 2006) on the meaning of HIV before conducting the test. By using questions and answers the health professional constructs mutual knowledge (Candlin, 2006) and the participants are aligned (Peräkylä and Silverman, 1991; Silverman, 1997) as the health professional is eliciting the answers from the women, and the women are, in turn, obtaining more information from the health professional.

Although HP4 explicitly invites an exchange of knowledge with the women, the formulation of his questions and talk, to an extent, presents a potential minimisation of the contribution that the women can give. By controlling in this way, HP4 acts as a gatekeeper on what kind of knowledge about HIV/AIDS the women need to reproduce with him in this context (Vickers et al., 2012). The use of question and answer forms is common in medical settings, they are a form of "medical interview", which formulates a discourse to attain institutional goals where by using questions and answers medical practitioners, for instance, are able to control the conversation (Ribeiro, 1996). The health professional uses the questions to elicit information from the women thereby encouraging them to share what they have. The women give responses, albeit rather short ones, for example in lines 25 and 27 where the responses are 'sharing razor blades" and 'sex' respectively, and the women did not elaborate on their responses. The brevity of the answers could be either because of the formulation of his questions that are eliciting short answers, or it could mean that the women are not free to elaborate as the health professional expects them to. Other studies in medical settings have shown that the formulation of questions can make a difference in patients' responses, especially when soliciting patients' concerns (Robinson, 2006). Since the kind of responses the women give depend on the kind of questions asked, the minimal responses may be co-constructed with the health professional (Vickers et al., 2012).

Some women may have been constrained to share their knowledge with the group – a reason that was stated by one woman in an interview: "being in a group, and for you to say something and ask questions one just feels scared, it is hard to say anything during the session" (W4). Nevertheless, HP4 (in Example 4.8) encourages participation, and most of the women provide their responses to his questions, and although minimal in some cases they are still helpful in engaging the women in the development of the talk.

In Example 4.8, HP4 leads the women in what to say; although the form of the questions is limiting, this style of talk still gives the women the chance to present what they know. There is a distribution of agency, each according to their available information repertoire and role of participation in the interaction. The women when granted the opportunity are speaking but HP4 still has the authority to facilitate the discussion. The extract in Example 4.8 is derived from Step 2 of the talk (according to the Counselling Protocol, see Table 4.1). This is the stage during which the participants reproduce basic information about HIV, but at a later stage, i.e. Step 4 (HTC Session overview) when the health professional speaks more than the women, it is clear that HP4 is the one in

charge of the talk and he is the one to ask all the questions. There are no instances of questions initiated by any of the women, or comments in the talk by HP4. This suggests that there can be a joint contribution of information by the health professional and clients, but the contributions of each are differentially distributed during certain phases of the talk (e.g. Hamilton, 2004). For instance, the clients may have a chance to speak more in Step 2 than the rest of the steps, thereby resulting in differences in distributions of agency exercised by each of the participants (Moore, 2005). The health professionals in HIV counselling have the expertise, and they have the clear goals of the talk, on the other hand, the women have the knowledge but it takes the agency of the health professional to elicit the knowledge from the women. Nevertheless, the women sometimes give minimal responses and seem to demonstrate less agency in the interaction. There are various stages of the talk during which the HP4 demonstrates more agency than the women; however, there is also collaboration in the talk as the clients respond to the questions, thereby enabling HP4 to construct his talk based on the women's knowledge. The notion of the participants' agency and how it is enacted at various stages in the talk will be discussed in more detail in Chapter 6.

4.4.2. Health professionals acknowledging clients as co-distributors of knowledge

As shown earlier from the interview data, some of the health professionals indicated their awareness that the clients already have information on the basics of HIV/AIDS. That perception is also shown in interactional data, as some explicitly or implicitly acknowledge the women as having the necessary information about how to prevent HIV/AIDS. The following excerpt, (Example 4.9) is from a talk by a female nurse during a group counselling talk, in which she positions the women as co-distributors and experts of knowledge.

Example 4.9: Excerpt from interaction between a nurse and pregnant women

Context: HP3, a female counsellor/nurse, giving a talk to a group of 23 pregnant women. At this point in the talk the nurse encourages discussions between women and their spouses on condom use and the importance of HIV testing. W represents several women speaking at the same time, while codes W1, W2, W3 etc. refer to individual women in this example.

1	*HP3*:	*Mukamariza muja (.) amayenera kuchotsa ndi ndani?*
	HP3	when you have finished (.) who is responsible for taking it off?
2	W1:	*Inuyo (.) amayi*
	W1:	You (.) the woman.
3	*HP3:*	*Muchotsa ndi <u>inu</u> amayi (.)*
	HP3:	<u>You</u> the woman is to take it off him (.)
4		*Tikumvana eti? Ochotsa ndinu*
		we are together right? you are the one to remove it
5		*manyazitu <u>ayi,</u> tisamapangetu manyazi*
		<u>don't</u> be shy, we should not feel ashamed
6		*osathimitsa nyali::yi*
		do not put out the lamp during this no::
7	W:	*He he he he he ((Kuseka))*
	W:	Heh heh heh heh heh ((laughter))
8	W1:	*Nyali izikhala isanathime*
	W1:	The lamp should be kept alight
9	W:	Heh heh heh heh heh
		((laughter and indistinct chatter))
10	HP3:	*Nde zimenezo zikamachitika timakhala tadziphimba bulangete*
	HP3:	Instead when all this is happening we tend to hide in blankets
11	*W:*	*((kuseka)) he he he*
	W:	((laughter)) heh heh heh
12	W2:	*Ee, nyali yothima*
	W2:	Yes, the lamp is put out
13	HP3:	*Zinthuzitu sizikufunika manyazi*
	HP3:	We should not be shy about these things
14		*Chifukwa chonena kuti tikuyenera nonse mutetezane eti?*

because you are supposed to protect one another right?

15 *Nonse muthandizane*

You have to help one another

[ten turns omitted in which she talks about what women should do when using a condom]

16 *Nde ngati utakumana ndi mavuto oterowo*

So if you encounter such problems…

17 *Kuti akupangazoterozo (.) kambiranani,*

when a man is doing that (.) you should discuss it,

18 *komabe zofunika kuti munthuyo ngati ukuwona kuti zikuchitikabe,*

nevertheless if the person sees that it is still happening,

19 *nyamulanani, mubwere nawo kuchipatala*

take him, bring him to the clinic

20 *tidzaafotokozere bwinobwino (.) mwina inuyo mukhoza kutani?*

so that we should clearly explain it to him (.) perhaps you may what?

21 *munena ziwiri zitatu zina >mwayiwara<*

you may say two or three things to him >and you forget the rest<

22 *koma mukabwera nawo kunoko*

but when you bring him here

23 *adzakumane ndi achipatala*

he will meet health practitioners

24 *adzawafotokozera adzawauza bwinobwino zoyenera kutani?*

who will clearly explain to him what he needs to what?

25 *zoyenera kuchita (.) eti?*

what he needs to do (.) right?

26 *W:* *((ena)) Eee*

W: ((a few)) Yes

27 HP3: *Chifukwa apapa timatha kuphunzira, koma zonse timakumbukira?*

Because we learn here, but do we remember everything?

28 *Tikakambirana ziwiri, zitatu (.) zina tayiwara*

We discuss two or three things (.) we forget the rest

29 *Nde tikaona kuti zikuchitika chitika*

so when we see that it is happening again and again

30 *tingowatenga tibwere nawo kuno*

let us just bring him here

31		*Nanga simunthu ukayezetsanso magazi aja (.)*
		Since after the blood test (.)
32		*Umayenera ukamuuze mnzako uja (.) eti?*
		you are supposed to share the results with your partner (.) right?
33		*Umayenera ukamuuze mnzako uja kuti nayenso adzayezetse*
		You are to tell your partner so that he comes for a test as well
34		*nayenso atani? athandizikenso*
		he should also what? He should also be helped
35		*Tikumvana eti? (.)*
		we are together right? (.)
36	*W:*	*((ena)) Mmm*
	W:	((a few)) Mmh

In the interaction quoted in Example 4.9, HP3 constructs the women as co-experts of knowledge about HIV/AIDS. HP3 creates an in-group with the women by using collective pronouns, and encourages shared action between the women and the health professionals. In the talk HP3 uses various subjects as actors in her statements. She uses singular pronouns 'you' (the woman) and collective ones "we and us" (the women and herself) in relation to 'he' (the man) at different points in her talk. This creates an "us" (women) vs. "them" (men) dichotomy as she collaborates with the women. The nurse and the women's collaboration seems to be strengthened by the similarity of their gender, making it easy for the nurse, as a fellow woman, to offer advice and encourage the women. In the stretch of the talk quoted in Example 4.9 she has used 'we' and 'us' more often than 'you'. The use of 'you' for instance in lines 1-3 where she opens her advice with double subjects 'you' and 'the woman' indicate her attribution of agency to the women. She affirms the woman's response (W1) with a repetition and emphasis to the agent "you, the woman".

'The woman', set apart from 'the man', is constructed as having the agency in condom use. Furthermore, in line 3, she mentions the word *"inu"* "you" with a strong emphasis, which serves to strengthen her presentation of agency to the women. She repeats the word "you" in line 4 as she asserts that the woman is the one to take the condom off the man. Other instances of "you" as attributors of agency are used in lines 14 and 15, where she encourages the women and their husbands to 'support' and 'help one another'. This way she encourages agency in the women. In medical discourse 'you,' among other

things, may indicate client or patient-centredness, it encourages involvement of the participant in the talk (Staples, 2015). In this case there is a direct reference to the women as the experts who have to share information (lines 31-33) and also act assertively with their husbands during sexual intercourse (lines 3-6).

HP3 uses collective pronouns to encourage agency among the women. HP3 repeatedly encourages the women not to be shy (lines 5-6), a statement which she repeats in line 13 "we should not be shy about these things". 'We' in this case is used to align herself with the women, thereby creating an in-group with the women and "men" as another group. HP3 reiterates the women's active role, in fighting HIV, in relation to the men (who are not present in this forum) when she further points to the need for the women, if they fail to talk to the man by themselves, to bring the man to the clinic so that together with the nurse they can use their expertise to talk to him (lines 22-23 and 29-30). By using inclusiveness and collective linguistic devices such as "let us…" the nurse encourages the agency of the women in the discourse of HIV/AIDS (Vickers et al., 2012). The husband here is constructed as a benefactor with the woman and health professionals as the actors responsible for his wellbeing (see van Leeuwen, 2008). She constructs the women as co-experts, i.e., the women alongside herself as fellow experts who have shared a lot in the past as indicated in the statement "Because we learn here… but do we remember everything? We discuss two or three things >we forget the rest<" (lines 27-28).

By being routinely exposed to the information at the health centre pregnant women might become knowledgeable about HIV/AIDS and other illnesses that are discussed during the educational and counselling. This situation is similar to what Sanderson and Angouri (2013) describe as an "expert patient" where patients with rheumatoid arthritis gradually displayed expertise in the illness due to prolonged exposure to medical resources.

The nurse (HP3) also uses interactional strategies that recognise women as co-distributors of knowledge. She employs humour and teasing which may work to reinforce solidarity with the women (see Chimbwete-Phiri and Schnurr, 2017). For instance HP3 teases the women by bringing a humorous scenario "we tend to hide in blankets" (line 10) while encouraging them about their role of protecting themselves and their husbands. As HP3 advises the women about condom use (in line 6) she states it in a humorous way such that the women respond with laughter (lines 7, 8 and 9) to

her humorous teasing statement. She teases the women about putting off the light during sex and they all laugh (in line 6). HP3 encourages the women to "discuss" with their husbands and not to be shy about HIV/AIDS issues. She does not wait for the women to respond but proceeds with her advice, and in a teasing way encourages the women's pro-activeness during sex.

By using humour, HP3 makes fun of the situation, minimising the formality of the situation, but she also tries to downplay the power differences that exist between her and the women (Robinson, 1991; Wender, 1996). Her use of humour eases the situation and encourages the women to comment. For instance, amidst the laughter a woman rephrases the nurse's statement "do not put out the lamp during this no" (line 6) by presenting her advice "the lamp should be kept alight" (line 8). This way the woman seems to accept the nurse's statement and amplifies it as a way of co-constructing advice to her fellow women with the nurse.

The woman (W1, line 8) actively contributes to the nurse's humour thereby causing the rest of the women to laugh even more, to start making comments, and to talk about the issue in an inaudible group chatter following her remarks. The women continue to laugh as the nurse proceeds to encourage them about being assertive in condom use during sex. The women's laughter appears to encourage the nurse to say more and even tease them more, when she says "…instead we tend to hide in blankets" (line 10). Consequently, the women collaborate with her on this statement by adding comments and laughing more. This moment of laughter encourages another woman to assert the nurse's statement of line 10 "do not put out the lamp during this" when the woman laughs and jokingly says "Yes, the lamp is put out" (in line 12) which functions as a confirmation of the women's practice that the nurse is referring to and she co-constructs the said practice with the nurse.

The women's laughter and comments seem to provide encouragement for the nurse to continue with the advice, while at the same time constructing their roles as leaders in the prevention of HIV. By suggesting women's participation in condom use the nurse implies that the women have knowledge about HIV that they can share with their husbands. The women are considered fellow experts and co-distributors of the knowledge with the health professionals. This frequent exposure to HIV/AIDS information may create expertise about HIV/AIDS in the women, than what would be obtained by other groups of health centre users because patients and clients can become

experts when they obtain a lot of information about certain conditions (e.g. Sanderson and Angouri, 2013).

As HP3 gives lengthy advice to the women, she continues to involve them by checking their understanding. For instance, in line 4 HP3 checks her proposition by asking the women if they are together with her. She checks their understanding and togetherness again in line 35. Such questions as "are we together?" and "right?" are used again and again throughout the entire talk, a strategy she uses to check a shared understanding with the women. Use of tags, such as "right?" may also be used by medical practitioners to show solidarity with the patients and "appeal to shared knowledge" (Harres, 1998: 122). This strategy is what is mostly used by teachers in classrooms, where such types of questions are used as transition markers, used to hold the listeners' attention, as well as to call for harmony (Walsh, 2011).

On the level of content of talk, this interaction presented in Example 4.9 is focused more on advice giving to the women than just sharing information. The nurse advises the women to be assertive. On the other hand, the women are constructed as knowledge bearers but they are faced with the problem of men who are not using condoms correctly. As a result the woman who has the information is encouraged to initiate and discuss with the man. The woman is constructed as an agent that should help the medical team share the information with others, in this case, the husbands. The nurse proceeds to state what the woman should do, in lines 28 to 30 in which she suggests collaboration of the women and the hospital staff in convincing the man to use the condom appropriately.

The health professional in Example 4.9 has constructed the women as co-experts, and co-distributors of knowledge about HIV. However, in some instances she acknowledges the limitations of the women to act, for example in lines 21-22 and 28-30, where she encourages the women's participation in constructing their role in the management of HIV/AIDS. In this instance, she sets the health professionals apart from the women as experts against the less knowledgeable women "bring him to the clinic so that we should clearly explain to him" (lines 19-20). "We" may serve to refer to the institutional authority and expertise of the health professionals or the clinic (Harres, 1998), in this case as those who are able to deal with the medical knowledge, particularly because the women may forget to mention everything to their husbands but they (professionals at

the clinic) will talk to the men[3]. In this talk the nurse attempts to construct the women as co-experts in the knowledge of HIV because of their exposure to counselling and testing but still faces the dilemma of the ambiguity of their role as experts, and fellow women. Similarly, according to what is stated in this example, the women have a challenge of applying their knowledge because of their subordinate position within the marriage.

Based on my observations, pregnant women are exposed to much more information about HIV and other health issues at the health centres than other healthcare users. This is so because of the talks that are held during prevention of mother to child transmission (PMTCT) programmes and child clinics, during which they are exposed to detailed discussions about HIV with the health professionals (see also NSO, 2014, Makwiza et al., 2009). It was observed that in this context spouses were never present in the antenatal and children clinics, despite health promotional messages on mass media that encourage male involvement.

The analysis indicates that health professionals recognise the pregnant women as informed regarding knowledge about HIV/AIDS. This confirms what was noted from the interviews when most of the women acknowledged having a knowledge base about HIV prior to the interaction with the health professionals, but still they recognise the importance of additional information obtained during the group counselling. The women's existing knowledge creates the clinic as a potentially collaborative forum for the reproduction of knowledge. The women gave correct answers to the health professionals' questions (Example 4.8), they commented on the nurse's remarks, laughed together with the nurse, and responded to her encouragement (in Example 4.9).

4.5. Chapter conclusion

In this chapter I have analysed the reproduction of knowledge at a macro level to lay the ground for the institutional and individual understanding of the talk, before presenting a detailed micro analysis of the discourse strategies employed by participants in the reproduction of knowledge in Chapter 5. The current chapter has given a general picture of what reproduction of knowledge about HIV means in the interactional context of group HIV/AIDS counselling in the antenatal clinic in Malawi where data were

[3] The contradictions that arise in the talk are discussed in more detail in Chapter 6.

collected. This was done by referring to audio data, official HIV guidelines, and participants' responses to interview questions.

The analysis has pointed out that the ethos of client-centredness in counselling for this context is widely recognised. There are explicit attempts by health professionals to actively engage the clients in reproducing their knowledge about HIV/AIDS. The guidelines have highlighted the need to 'discuss' information with the clients, an activity that is also referred to repeatedly by the health professionals during interaction in the talk. Analysis of interview data has defined the counselling forum as a site of reproduction for the clients, as opposed to a site where new knowledge is obtained. This micro analysis has identified that interaction of health professionals and their clients is constituted by an ideology of collaborative reproduction of knowledge. This reproduction of knowledge is not the only activity in these forums, there was also negotiation of different forms of knowledge. How this reproduction of knowledge is achieved at the micro level of interaction, and the extent of collaboration and negotiation will be further explored in the next chapter.

In Chapter 5, some of the discursive strategies that the counsellors employ to negotiate knowledge about HIV with the clients are discussed. By analysing the micro details of interaction of the health professionals and the pregnant women it will enable us to see what takes place at every stage of the talk and how each interlocutor enacts their understanding of HIV via the talk (Jacoby and Och, 1995), thereby contributing to the larger discourse of HIV/AIDS.

Chapter 5: Negotiation of knowledge in antenatal HIV group counselling

5.1 Introduction

This chapter continues to develop the argument of the previous chapter, which suggested that the reproduction of knowledge is not just monologic but the participants are jointly engaged in the dialogic reproduction of knowledge of HIV/AIDS during the counselling. However, it is important to address the micro details of the talk further in order to understand how various discourse strategies are employed by the participants to negotiate this reproduction of knowledge. The discourse of HIV counselling presents the need to place the client at the centre (see section 4.3.1) and discuss with them rather than just presenting information to them. The ethos of group counselling in this healthcare context propagates discussions and clients' centrality in the discourse. This requirement, in turn, presupposes that there is reproduction of knowledge among the participants. Chapter 4 presented evidence, mainly at a macro level, of how the health professionals, as institutional agents, reproduce knowledge about HIV/AIDS as a joint activity with their clients. Thus, the current chapter analyses the micro details of the discourse strategies that the health professionals and clients use in this reproduction of knowledge. Particularly, it demonstrates how the participants negotiate knowledge about HIV/AIDS during verbal interaction. The next chapter, Chapter 6, adopts a critical approach – drawing on CDA approaches to link the the interaction with the social and institutional context – in understanding why the health professionals use the discourse strategies in ambiguous ways that are sometimes counter to the purported collaborative reproduction of knowledge. Chapter 7 will carry out a synthesis of the analyses presented in Chapters 4, 5, and 6.

The current chapter demonstrates how the health professionals and clients negotiate different types of knowledge about HIV/AIDS in their talk. It is important to mention here that focusing on how the participants negotiate knowledge does not negate the existence of power structures in this context; these do exist, but the examples show how they are enacted as a matter of degree – there are times when the participants are a bit flexible in that the women enacted more agency than in other cases. There is a degree to which some of the women enact agency and the degree is affected by the extent of control of the health professionals. Thus, I do not claim that the sessions are

deterministic, or that power is entirely absent, but there are specific modalities of negotiation according to different participants.

The format of the talk requires the women to answer questions and relate what they know to the health professionals, while the health professionals utilise such formats to deliver information to the women. By recalling and sharing what is already known about HIV/AIDS, each interlocutor is reproducing their knowledge (Fairclough, 1992) and this takes the form of 'declarative' knowledge. By presenting to the group their 'declarative' knowledge, participants seem to recall previously held knowledge about HIV/AIDS. On the other hand, there are instances when the participants have to explain 'how to do' and 'what to do' in relation to HIV/AIDS practices; these vary according to individual interpretations and hence are, arguably, related to procedural knowledge (see Anderson, 1990; Thompson and Thompson, 2014). Consequently, in this chapter some examples may be about negotiating already existing factual knowledge (declarative knowledge) while others may be about negotiating application of practical knowledge (procedural knowledge) in the talk (see pages 27-28).

Furthermore, it is noted in this study that, discursively, the participants refer to local elements to explain medical information, which implies that they have group knowledge, and this type of additional knowledge is classified according to van Dijk's (2003a) typology as social knowledge, depending on who is involved – it can be interpersonal, group or local knowledge. This type of knowledge is also categorised as shared or common-ground knowledge and is presupposed by members in the discourses (van Dijk, 2002). This chapter will adopt the notion of local knowledge to refer to all shared culture-specific knowledge of the participants in the data, whether it is presupposed or not (van Dijk, 2003b; see also MacDonald et al., 2009).

The analysis identifies that two broad kinds of knowledge are negotiated in the data: declarative (medical) knowledge, and procedural (local and experiential) knowledge. Within the medical knowledge there is further categorisation, on the one hand there is technical medical knowledge that is highly specialised by the medical personnel and common medical knowledge that is presented in everyday talk to lay audiences; on the other hand, there is local and non-specialised knowledge that relates to clients' everyday practices (MacDonald et al., 2009; Van Dijk, 2002). Some scholars, however, have argued against such categorisations because both the client and health professional can employ the medical and the local discourses, thereby implying a co-existence

(Silverman, 1987) and elsewhere it has been argued that local knowledge depends on the community one is referring to, as some communities have power in that their local knowledge becomes the authorised knowledge (Canagarajah, 2002) hence problematizing the use of local knowledge. As described in Chapter 2, section 2.3, local knowledge is that which is derived from the people's lived experiences and is outside the technical and authorised knowledge (Higgins and Norton, 2010). By using examples from the data, the contribution of each participant demonstrates how the various sets of knowledge of HIV are negotiated in this interactional setting, and reveals the extent to which the participants are involved.

The discourse strategies that the health professionals use operate at two levels. The first one is to do with the organisation of the talk, where the health professionals utilise question and answer forms to check women's knowledge of HIV/AIDS, and to facilitate discussions. The second level is to do with the content of the talk where the health professionals deliver information by mobilising presupposed shared knowledge, such as metaphors, analogies to simplify technical information, and references to other discourses. The chapter opens by focusing on the discursive strategies employed by the health professionals around the organisation of talk before moving on to the knowledge resources that they use to simplify their talk.

5.2 Organisation of the talk

This section will show how the health professionals organised their talk to ensure that the women are involved. It will show that by using question and answer forms the health professionals ensured that they are not just delivering information but are actually engaging the women in the talk. HIV counselling is an activity type which in this context includes three discourse types (Sarangi, 2000), information delivery, advice giving, and interview format (Peräkylä, 1995; Peräkylä and Silverman, 1991; Silverman, 1997). Levinson (1992: 69) refers to activity types as those "goal-defined, socially constituted, bounded, events with constraints on participants, setting and so on"; they define how an activity is institutionally situated. The interactional data of the study reveals that HIV counselling, as an activity type, predominantly uses the interview format (discourse type) during which the health professionals do not just give information and advice but they ask questions and expect the clients to give answers. Question and answer forms were commonly used in the talk.

The use of question and answer forms revealed a considerable amount of turn sequencing that, quantitatively, gave the women an almost equal number of talking turns to those of the health professionals. In an average talk of 25 minutes, one of the counsellors had 96 turns while the women had 94. In this case "turn" does not necessarily mean how much is said, but the chance given by a speaker for a listening party to respond and they are referred to as 'turn-constructional units' (Sacks et al., 1974: 701). The lengths of the turns indicate that health professionals do most of the talking while the clients' turns are relatively short in length but they are all examined with equal importance since one word can convey a complete thought, just as a long sentence would (Mahmood and Rana, 2006). The turn lengths may vary from one word long to longer stretches of talk. The quality of the turns in this case also varies, where for example the women sometimes give minimal feedback such as "mmh", as continuers or responses to the health professionals' long turns of talk while sometimes they answer the questions, give comments and ask questions.

The sequence of the talk in the context of this study is analysed to understand how each interlocutor negotiates meaning as they contribute to this reproduction of knowledge. The sequencing of turns was mainly structured along question and answer forms. By using questions the health professionals transferred speaking turns to the clients. The next section will detail how question and answer strategies were utilised by the health professionals to sequence their talk.

5.2.1 Question and answer forms

As typically used in medical conversations (MacDonald, 2002; Robinson, 2006), the health professionals asked the women many questions, rather than simply delivering information. For example, in a 25 minutes' conversation one of the health professionals asked 55 questions that required the women to give information and an average of 90 tagged questions that simply checked understanding such as "are we together?" or "not so?" or "right?".

The different types of questions relate to different types of knowledge that they entail. Knowledge that the various questions elicited was either declarative or procedural (Anderson, 1990); there were also some questions that required technical or expert knowledge. For instance where the women were required to give factual information

for instance, “what is HIV?” is categorised as declarative knowledge because they are conveying their understanding of facts, or if they are required to explain how HIV transmission occurs from mother to child while the child is in the womb then it is considered expert and technical knowledge; however, if they are presenting the application of their knowledge, such as how they will protect themselves so that the baby is not infected with the virus, or where they relate to living experiences, it is considered procedural knowledge (Sarangi, 2007; Thompson and Thompson, 2014). During the talk, local knowledge – in the form of common-ground knowledge (Geertz, 1983; van Dijk, 2002, 2003b) – was oriented to when negotiating technical and medical knowledge.

In this interactional context, the health professionals employ different types of questions as is typically used in classroom discourse. An initiate, respond, feedback (IRF) exchange structure is predominantly used in the talk (Sinclair and Coulthard, 1975; Walsh, 2011, see section 4.4.1). Because of its similarity to classroom discourse the kinds of question asked in the talks are categorised according to the taxonomies of classroom discourse where different questions perform different functions. Table 5.1 presents the main types of question and the type of knowledge that they seem to target, with examples. The categories are adapted from Faruji (2011) who presents questions according to categories, such as factual, empirical, productive and evaluative. Each question type is illustrated with an example from the data.

Table 5.1 Question types and knowledge types

Type of question	Type of thinking	Examples from the data	Knowledge type
Factual	Recalling information, showing comprehension	What is HIV? What are the three ways that a mother transmits HIV to a child? What about during delivery, how can a mother transmit the virus to the baby?	Declarative
Empirical	Application, integrating, and analysing information that is given	What is the difference between HIV and AIDS? Is it possible for a person to have HIV without suffering from AIDS? What are the dangers to the baby, if a pregnant woman is infected with a sexually transmitted disease?	Declarative
Productive	Synthesising knowledge, being creative with the given information	How can you protect your child from contracting HIV? How will you protect yourselves from contracting the virus if you are seronegative?	Procedural
Evaluative	Making judgements and evaluating	Should an HIV positive woman breastfeed her baby or not? What is the right time to start having sex after giving birth?	Procedural

Some scholars have categorised questions according to the question situation or the questioner's intentions: namely requesting information that is not known to the questioner; rhetorical questions which may not require answers but are intended to provide information; examination questions during which the questioner asks because he or she wants to know if the listener knows the answer, also referred to as knowledge checking or display questions (Athanasiadou, 1991). The latter, display questions, are commonly used by teachers to check if the students can recall what was taught in the previous lesson, but teachers can also use what are called referential questions that they do not know answers to, especially those that require opinions.

The questions identified in the current data, and presented in Table 5.1, fall into the aforementioned functional categories and with varied linguistic formulations. Linguistically there are those questions that are open-ended and are prefaced by 'what', 'how', or 'when' forms; there are some closed questions that require a 'yes' or 'no'

answer; another group of questions are those that are tagged at the end of statements to check the women's understanding "are we together?" "not so?" and to obtain affirmation of certain propositions "right?".

The section will further demonstrate that there were three effects that emanated from the different question and answer forms. The first one is that the question and answer format worked to check women's knowledge about HIV and AIDS and enabled them to share what they know; the second question and answer format facilitated application of knowledge and also discussions, whereas the third format was used by the health professionals to check if the women were following the talk.

Example 5.1 illustrates a combination of question types used by the health professionals, which involved the women in contributing various kinds of information.

Example 5.1: Utilisation of question and answers in the talk

Context: HP1, a female counsellor at the beginning of her talk to a group of 14 pregnant women. This talk is held prior to conducting an HIV test, and here she is setting the agenda of the talk. HP1 represents the female HIV counsellor, W refers to all the women in the group while W1, W2, etc. are for turns of individual women.

1	**HP1:**	***mmm chabwino, inuyo ngati amayi woyembekezera***
	HP1:	mmh alright (.) as pregnant women
2		*mukuwona kuti ndikofunikira kuti inuyo muyezetse magazi?*
		do you think it is important for you to have a blood test?
3	W:	*((ena)) [Eee]*
	W:	((some)) [Yes.]
4	W:	*((ena)) [Mmm] ndikofunika*
	W:	((some)) [Mmh] it is important
5	HP1:	*Kufunika kwake ndikotani?*
	HP1:	What is its importance?
6	W1:	*Udziwe mmene muliri mthupi mwako*
	W1:	So that you should know how your body is.
7	HP1:	*Mudziwe mmene muliri mthupi mwanu, eti?*
	HP1:	You should know how your body is, right?
8	W:	*Mmm*

	W:	Mmh
9	HP1:	*Ndeno mukadziwa?*
	HP1:	And when you know?
10	W2:	*Kutetezera mwana amene tikumuyembekezerayo*
	W2:	To protect the baby we are expecting.
11	HP1:	*Kumutetezera mwana amene tikumuyembekezerayo, eti?*
	HP1:	To protect the baby you are expecting, right?
12		*Makamaka ngati mwapezeka kuti muli ndi HIV, tili limodzi?*
		Especially if you are diagnosed with HIV, are we together?
13	W:	Eee
	W:	Yes.
14	HP1:	*Ngati mulibe kachilombo? (2.5)*
	HP1:	If you do not have the virus? (2.5)
15	W2:	*Kudzisamala*
	W2:	To take care of yourself.
16	HP1:	*Kudzisamala?*
	HP1:	To take care of yourself?
17	W2:	*Eee*
	W2:	Yes.
18	HP1:	*Mudzikadzisamala bwanji?*
	HP1:	How will you protect yourselves?
19	W3:	*Mmene ungadzisamaliremo*
	W3:	Whatever you can do to take care of yourself.
20	HP1:	*Awa akuti 'mmene ungadzisamalirire'*
	HP1:	This one says 'whatever you can do to take care of yourself'
21		*Ena? (.) tikuganiza kuti tidzikadzisamala bwanji?*
		Others? (.) How will we take care of ourselves?
22		*Tidzikadzisamala bwanji tikapezeka tilibe kachilombo?(.)*
		How will we take care of ourselves if we are free of the virus?
23	W4:	*Pokapewa kuti tisatenge*
	W4:	By preventing it, so that we do not contract it.
24	HP1:	*Pokapewa kuti musatenge.*
	HP1:	By preventing it so that you do not contract it.
25	HP1:	*Mudzikapewa bwanji? Mayankho onsewo mukuperekawo*
	HP1:	How will you prevent it? All those answers you are giving

26		*ndi olondora, koma simukumasula. Tamasulani bwinobwino*
		correct, but you are not elaborati:ng. Please elaborate well
27		*(.) Mudzikapewa bwanji kuti inuyo musatenge kachilombo?*
		(.) How will you prevent it so that you do not contract it?
28	W4:	*Kuchepetsa anthu ogonana nawo, komanso kumakhala*
	W4:	By reducing the number of sexual partners, and also to get
29		*ukumayezetsa pafupipafupi, komanso kumadziwa kuti*
		tested frequently, and to know the person you are
30		*munthu >amene ukugona nayeyo< (.)ngati ali okhulupirika*
		>having sex with< (.)if he is trustworthy.
31	HP1:	*Amayi anzathu akuti kuchepe::tsa anthu ogonana nawo*
	HP1:	Our friend here says by redu::cing sexual partners,
32		*komanso kuyezetsa magazi, >komanso amene ukugonana*
		and having a blood test, >and the one you are having sex
33		*naye::yo< (.) akhale wokhulupirika (.) e:ti?*
		wi::th < (.) should be trustworthy (.) righ:t?
34	W:	*Eee*
	W:	Yes

The excerpt in Example 5.1 is a quick succession of questions from HP1 and responses from the women, a format that is common in medical interaction (Gleeson, 2009) and in HIV counselling which typically takes an interview and information delivery format (Peräkylä and Silverman, 1991). This successive way of questioning can be compared to chaining in informal conversations, whereby chaining a conversation is sustained by successive questions by one speaker to another (Mishler, 1975). In Example 5.1 the health professional uses different types of questions to elicit information from the women.

HP1 asks a question that requires either a 'yes' or 'no' response – a closed ended type of questions with a fuzzy functional category (lines 1-2). HP1 asks the women to evaluate if it is important to have a test or not. By asking this question she attempts to construct the agenda of her talk together with the women. In this case it is not expected that the women would say 'no', clearly the women affirm the agenda of the talk positively (line 3). It is interesting that some women respond to this question with a phrase, "it is important" rather than simply saying 'yes' as directly demanded by the

question, signifying that the question had an alternative way of answering and also suggesting active participation by the women. The question "what is its importance?" (line 5) follows from the closed question of line 1 and enabled the women to give a more elaborate response. One woman responds to the question (in line 6) and her response is picked up by HP1 who then repeats what the woman has said to reinforce the answer and evaluate it as correct. This type of questioning gives the women a turn to speak, though minimally, rather than just the health professional telling them why it is important to have the test. By using this question, HP1 enables some of the women to share what they know about the importance of having an HIV test.

Other open-ended questions require the women to explain how they are to protect themselves (line 18) and how they will prevent contracting HIV (line 25). These are productive questions, requiring the application of procedural knowledge. There is a quick succession of questions and answers in this excerpt in which case HP1 has less to say at this stage of the talk but she develops her talk based on the women's answers. For instance, she repeats one woman's response "to protect the baby we are expecting" (line 10) and extends it with additional information, "especially if you are diagnosed with HIV…" (lines 11-12). The woman's response has in a way influenced the direction that HP1 takes her talk from this point. If no answer is given by the woman, it may lead to a different point raised in the talk or change of topic. By repeating and adding her points to the women's answers HP1 jointly reproduces this piece of knowledge with the women. Thus, she delivers the information based on the women's answers.

The agenda of the talk – to encourage prevention of HIV transmission from mother to child – is covered by eliciting the information from the women rather than a mere presentation by the health professional. More questions are asked following the women's responses (lines 9, 14); these are open-ended questions but with an informal formulation, for example "if you do not have the virus?" (in line 14). HP1 uses shortened question forms, and informal questioning which could be matched with those that are used in informal conversations. Such shortened and indirect questions (e.g. lines 9 and 14) may mark informality, while more direct questions may indicate formality of the talk (e.g. Candlin, 2006). Nevertheless these types of questions and their succession may also sound interrogative and almost make it obligatory for the women to respond to the questions, hence demonstrating an enactment of power by HP1 (e.g. Wodak, 1997). She asks these shortened questions (lines 9 and 14) in quick succession as follow-up questions to the initial questions (of lines 1 and 2). This format of question

may be used either because the women's earlier response (e.g. line 6) is not convincing enough or because she wants the women to be more elaborating.

As the talk progresses the women become elaborate with their answers. As they respond to the questions, HP1 acknowledges the correctness of the women's answers and explicitly asks the women to elaborate their responses (line 26) when one of the women provides a brief answer (line 23). The woman (W4) responds to HP1's request for elaboration by extending her answer (lines 28-30), consequently she mentions up to three ways of preventing HIV in one turn, making it a rare case of elaborate answers. HP1 acknowledges the woman's response by repeating the information given and closes with a question that aims to check a shared understanding, "right?" (Harres, 1998). The rest of the women respond with a 'yes' (in line 34) to accept this piece of information. In this case the woman is the one who has provided the information while HP1 provides an evaluation or ratification by repeating it to the rest of the women (Walsh, 2011). These types of questions therefore are utilised to not only check the women's knowledge of HIV/AIDS but are also used to confer more agency on the clients, as in the instance of giving elaborate responses (lines 28-30).

The use of questions could also be seen as HP1 being in control of the talk and controlling the nature of the information the women should give (Ribiero, 1996; Vickers et al., 2012). In addition, by asking questions and ratifying the women's responses HP1 seems to check the women's knowledge against the legitimate knowledge appropriate to this institutional interaction (see Bourdieu, 1991). However, this questioning, to a large extent, facilitates an exploration of prior knowledge by the women; this is similar to those that are used in classroom discourse when questions are used by teacher to elicit information from the pupils although the teacher may already know the answers to the questions (Mehan, 1979). Similarly, the basic information presented by the women in Example 5.1 is obviously not new to the health professional but she acts like a teacher who is checking what her students know and facilitating reproduction of knowledge among the women.

HP1 knows the answers to the questions but she chooses to collaborate with the women in exchanging what is known about HIV. In the process, she constructs the client as knowledgeable. By using questions and answers, the counsellor focuses on making explicit some knowledge that they assume the clients have (Levinson, 1992). This way she reminded the women that the knowledge is from them too not just from her, and it

is ratified as correct knowledge by her repetition of women's response to emphasise it (lines 24 and 31). This is a strategy that positions the clients as collaborators in the reproduction of official knowledge about HIV.

HP1 achieved a high level of involvement of the women in her talk as reflected in the women's responses to her questions, thereby almost equalising the turn frequency; eventually her talk presented a rare case of a woman initiating a question, even when HP1 had not invited questions yet. Some open-ended question and answer forms were evaluative in nature in that they did not just require the women to give answers to the questions but facilitated a discussion among the women. Such types of questions were used in three out of the seven recorded antenatal talks. Example 5.2 illustrates two types of questions: those that are evaluative and productive, which engaged the women in a sort of discussion. The first to be discussed are those that were evaluative in nature.

Example 5.2: Questions according to type of knowledge

Context: This is an excerpt of a talk by a female health professional (HP3) during a group talk to 23 women. They are discussing the implications of getting pregnant when HIV positive.

1	HP3:	*Nanga mwana mtsikana woti wangopezeka nako kachilombo*
	HP3:	What about a young woman who has had a recent HIV diagnosis
2		*Koma mimba sanatenge::yi*
		but she has never been pregnant befo::re?
3		*>alibenso mwana< koma wapezeka ndi kachilombo*
		>she does not have a child< yet she has got the virus
4		*abereke kapena asabereke? Ee?*
		should she conceive or she should not conceive? What?
5	W:	((laughter and indistinct talk))
6	HP3:	*Nzokambirana, palibe ali ndi yankho lolondora kapena lolakwa*
	HP3:	This is a discussion there is no one with a right or wrong answer.
((Omitted 4 lines during which some women said she should conceive and others said she should not))		
7	W2:	*Ngati ndi [wob-]*
	W2:	If she can [con-]
8	HP3:	*[onse]watu tikunenawa ndiwobereka (.)*

	HP3	[both] of these women we are talking about are fertile (.)
9		*palibepo wosabereka apapayi*
		there is no barren one in these cases
10	W3:	*Abereke*
	W3:	She should conceive
11	HP3:	*Enanu mukuti bwa::? Abereke?*
	HP3:	What do others think? (2)
12	W4:	*abereke bola iye angotsata*
	W4:	She can conceive (.) as long as she follows
13		*njira yokumwa mankhwalayo*
		the recommendations for the medication
14	HP3:	*angotsata njira yomwa mankhwalayo?*
	HP3:	she should just follow the recommendations for the medication?
15	W4:	*Eya*
	W4:	Yes
16	HP3:	*Enanu mukuti bwa?* (2)
	HP3:	What are others saying? (2)
17		*Tikuti munthu akapezeka ndi kachilombo munthu ameneyo*
		we are saying, when a person has the virus that person
18		*asataninso? Asabereke, koma munthuyu*
		should not what? Should not conceive, but this particular person
19		*ndi mtsikana eti? Nayenso mwana akumutani?*
		is a young woman right? She also wants a what?
20	W:	*akumufuna*
	W:	a baby
21	HP3:	*Akumufuna. Nde abereke?*
	HP3:	She also wants a baby. So should she conceive?
22		*>ali ndi kachilombo koma< nde abereke asabereke (1)*
		>but she has the virus< so should she conceive or not? (1)
23	W:	((two)) *ameneyo asabereke*
	W:	((two))This woman should not conceive.
24	HP3:	*Tidziyankha::tu (.) tingoyerekeza kuti ifeyo ndife atsikana*
	HP3:	We should ans::wer (.) suppose we are young women
25		*Tili ndi kachilombo tingalorere kuti tisabereke?*
		with the virus, would we accept that we should not conceive?

26		*tibereka?*
		Would we conceive?
((Omitted 9 lines where the women gave different views, it is accompanied by laughter as the nurse made fun of their responses))		
27	HP3:	*Munthu ameneyoyo akhoza kubereka koma::no*
		this person can conceive bu::t
28		*akuyenera kulandira uphungu wotani?=*
		she is supposed to receive what sort of counselling?=
29	W:	*((ena)) = Wokwanira*
	W:	((few)) = adequate
30	HP3:	*wokwanira kuti akabereka mwana,*
	HP3:	Adequate, so that when she gives birth,
31		*>Mwanayo ngati akumfunitsitsatu eti?<*
		>that is if she really wants to have a child right?<
32	W:	*Eee*
	W:	Yes.
33	HP3:	*Sikuti izozo zasinthayi*
	HP3:	It's not that the proposition has changed
34		*zili momwe muja*
		it is the same
35		*wina aliyense amene wapezeka ndi kachilombo asatani?*
		whoever has the virus should not what? [conceive]
36	W:	[*asabereke]*
	W:	[should not conceive].
37	HP3:	*Koma iyeyo wafuna kuti akufuna kuberekako mwana (.)*
	HP3:	But she has chosen that she wants to have a child (.)
38		*Nde akuyenera kupatsidwa chani? (1.5) Uphungu woyenerera*
		so she must be given what? (1.5) Appropriate counselling
39		*kuti athe kudzisamala bwinobwino*
		so that she can take care of herself
40		*komanso kuti mwana akhale wachani?(.)*
		and also that the child to be born should be what? (.)
41		*wamoyo wabwino eti?*
		healthy right?
42		*Athe kudzisamala bwino eti?*

		She should be able to take proper care of herself right?
43	W:	*Eee*
	W:	Yes

In Example 5.2, HP3 engages the women in a sort of debate to understand what an HIV positive woman is supposed to do in relation to child bearing (she raises opinion questions: what do you think…?, what should be…?). HP3 raises a question that requires an 'either …or' answer from the women, "…should she conceive or she should not conceive?". HP3's style of questions is somewhat different from that of HP1 in Example 5.1 or HP4 in Example 4.8. In contrast, HP3 appears to allow a degree of autonomy for the women to express themselves in a form of debate. Prior to this question HP3 asked the women a similar question, if it is acceptable for a woman who already has a child but is HIV positive to conceive again, to which all the women said she should not conceive again. This extract begins with a follow-up question using a hypothetical instance of a young woman who is HIV seropositive and does not have a child but wishes to bear a child (lines 1 to 4). The question is typical of that used in classrooms for students to give their judgement or evaluative statements (Athanasiadou, 1991; Faruji, 2011). These questions require the answerer to take a stance and justify their position, thereby displaying their application of procedural knowledge.

In Example 5.2, the women are meant to choose a stance whether conception is an option for an HIV positive mother or not. In the turn that follows (in line 5), the women respond to the question but with indistinct speech as they murmur among themselves, which is an indication of a discussion that has been opened by HP3's question. HP3 downplays the women's fears to speak up and encourages them to contribute their opinion to the discussion (line 6). The women voice out different views, which is expected from the nature of the question, while some women murmur, which signals indecisiveness about their stance (lines 7-26).

HP3's questions work to stimulate participation of all the women (see lines 7-26). The women seem encouraged to speak, such that one woman does not just take a stance but provides an explanation "She (the woman) can conceive as long as she follows the recommendations for the medication" (lines 12-13). The woman finishes her answer with what this woman should do to ensure that she has a safe delivery, which suggests her active engagement in the talk. The woman seems to present procedural knowledge,

in as much as she knows that HIV medication is available and she constructs the medication as a way of overcoming conception barriers for HIV positive women.

The women's responses are used by HP3 to draw a conclusion to the debate (lines 27-31). After different stances are raised, HP3 concludes the discussion by raising her points about the matter (lines 37-42) which is in agreement with those that were raised by one of the women (lines 12-13). The nature of the question in Example 5.2 allows the women to express themselves, even with differences in their views, before the health professional gives her advice. This format, therefore, encourages stronger participation in constructing the deliberated proposition, such that as HP3 presents the conclusion the women strongly respond to support it (Buttny, 1996). For instance, they give an affirmation "yes" (lines 32 and 43) as HP3 repeats the proposition; in this case 'yes' sounds more engaging than the minimal feedback "mmh" that was commonly used in other parts of the talk.

In contrast to HP1 and HP4's styles, the formatting of the question and its repeated utterance allowed a joint effort of the majority of women before a conclusion is presented (e.g. Buttny, 1996). Although the health professional receives an elaborate answer from one woman towards the beginning, "that (such a woman) can conceive" (lines 12-13), an answer that she also presents in the end as a conclusion, she rephrases the question to directly relate to the women (lines 24 and 25) "suppose we are young women with the virus would we conceive?". This question seems to relate to the women's lives more directly than the hypothetical instance of "the young woman" such that more women talk and give alternative responses (omitted here). This kind of question functions to bring the situation closer to the women and some women's responses change from "she should not conceive" to "we would conceive" which creates a humorous instance as she teases the women on their answers that distinguish their actions from that of the 'other' woman (omitted between 25 and 26). This discussion creates moments of laughter, which not only creates a light moment in the talk but appears to grant the group a form of solidarity (see Chimbwete-Phiri and Schnurr, 2017 for more on humour in the consultations of the antenatal clinic). By laughing together and changing the responses, the women and HP3 seem to construct the difficulty of deciding about conception when one is HIV positive.

The health professional delivers her message using evaluative questions linked to possible life occurrences. She summarises the proposition that the medical institution

provides “that HIV positive mother should not conceive, but…,”; however, she relates to a real life situation where a young woman would still want a baby (lines 18-21) and by saying this she puts a kind face on the medical world as she includes the social needs of the HIV positive woman (Ribeiro, 1996; Tannen and Wallat, 2006). This way she combines two categories of knowledge – the local and the official medical knowledge – to present the acceptable practice. She emphasises the medical proposition to discourage giving birth but at the same time she recognises the women’s choices (lines 37-39). HP3 related this problem in an interview, when she stated that people know that they should not conceive when they are HIV positive, but there are still many cases of infected women conceiving more than once. Thus, detailed health care for such women is required at all critical stages of the pregnancy. It was also observed that there were different perceptions on the issue of conception for those with HIV seropositive status; this may explain why the health professional in example 5.2 realises the need to dwell on this matter at length.

Evaluative questions such as the one HP3 raises are effective not only in that they allow a lively conversation to occur among the participants but they also allow the women to evaluate their own knowledge (see also Athanasiadou, 1991). As the women take a stance on the issue, they apply their procedural knowledge.

The women’s involvement in constructing a conclusion to the debate is further demonstrated in the way HP3 uses incomplete statements to construct a turn for the women. The raised intonation at the end of a sentence “she is supposed to receive what sort of counselling?=” (line 36), is a turn construction unit for the women to complete the sentence. This is picked by the women at the beginning of line 37 where they say “=adequate” signalling a jointly constructed sentence (also lines 19-21, 28 and 29). Significantly, such a construction is also used to present the conclusion of the debate: “whoever has the virus should not… [“conceive”] (lines 35-36 ff). The unanimous utterance of “conceive” as evidenced by the speech overlap of HP3 and the women (between lines 35 and 36) signifies a consensual conclusion of the matter. This style of speech was commonly used by other health professionals as well, e.g., HP1 (Example 5.3) and HP4 (not shown in the thesis).

Within the talk there are some instances where completion of the incomplete statements was not obvious to the women. For example, when the nurse says “she must be given what?” (line 38); although she paused to construct the women’s turn, they did not say

anything, instead she finishes the sentence herself. This completion of this statement was tricky perhaps because the ending of the sentence "appropriate counselling" (line 38) is not an obvious one and perhaps other options of completing the statement are possible. In most cases, however, the women attempted to complete the statements together with HP3.

Another common form of question to note in this excerpt (5.2) are the questions that are used to check a mutual understanding of the participants in the talk. By using these formulations of questions the health professionals ensure collaboration with the women. In lines 31 and 42, HP3 presents her statements and tags them with the question "right?" to check the women's understanding. In both cases the women, respond with a "yes". There may be various linguistic functions of these questions, i.e. checking understanding and confirming mutual agreement as the speech progresses, or they may also function as vocal segregates to fill naturally occurring speech pauses. According to Harres (1998) tag questions can function ambiguously in medical encounters as a form of control or a means of patient involvement. In this case the health professional appears to achieve continuous participation of the women by using these questions for, as shown here, they respond strongly (with a "yes" e.g. lines 32 and 43).

This section has demonstrated that the types of questions asked during HIV group counselling, as in general medical interviews (Robinson, 2006), influence the quality of answers and level of participation of the clients. It has been demonstrated that by using questions of various types the health professionals invited the women to take their turns in speaking and to convey what they have learned and known about HIV. Just like in classroom discourse, questions are a resource that is used to elicit participation of students, and to show the knowledge (or knowledge gaps) they have on a topic (Levinson, 1992). However, the variations between the health professionals (for example HP1 and HP3), where some allowed more agency on the women in the talk than others, imply that more agency could be portrayed by the women if the nature of questions' style are considered. The question and answer forms are a useful strategy in delivering information to the clients, facilitating an exploration of knowledge (Peräkylä and Silverman, 1991) and eliciting participation (Harres, 1998). Consequently, to a large extent the women show that they are well informed and are able to recall knowledge and negotiate it in this exchange process but are sometimes limited by the nature of the questions. The next section describes how the health professionals facilitate a negotiation of knowledge by drawing from shared knowledge resources.

5.3 Orienting to shared resources

This section will look at how the health professionals orient to possible group knowledge between themselves and the women. The data in this section demonstrate the incorporation of local knowledge and group knowledge (see van Dijk, 2002) to reinforce the medical discussions. One of the discursive strategies used by the participants is drawing information from presupposed group knowledge sources, i.e. mass media. They also use metaphors and fictional examples to explain technical information in ways that the women should understand. Metaphors are defined as representations of our thoughts about a concept as "we talk and potentially think about something in terms of something else" (Semino, 2008: 1) and linking a target and a source in ways that realise our thinking and how we view the world (Lakoff and Johnson, 1980; Demjén and Semino, 2017).

The use of metaphors as a vital linguistic resource in healthcare communication has mostly been evident in patients: for instance when patient's use of metaphorical expressions is seen as a linguistic resource that empowers patients to describe their pain hence eliciting responses according to creativity, detail and complexity of the metaphorical descriptions (Semino, 2010); and they are useful in making sense of and communicating one's experience of physical illness (Demjén and Semino, 2017). When used in therapeutic encounters by patients with mental health problems due to their "contextual richness" they facilitate a collaborative relationship with health practitioners (Tay, 2017). In this study, by using metaphors, the health professionals include the women in the talk since such use of metaphors constructs an in-group and indexes something that is shared among the interlocutors (Gordon, 2003; Hilligoss, 2014). The health professionals also engage the women by making reference to other channels of communication that were considered as possible contributors to women's knowledge namely, radio, church, and interpersonal communication. Examples 5.3, 5.4 and 5.5 below demonstrate how metaphors, simplified language, narratives and shared (local) references facilitate the women's involvement in the talk.

5.3.1 Local or common linguistic resources

A number of metaphors were used by the health professionals to explain technical concepts or as euphemisms to replace sex-related language with less offensive language. The examples are presented to show how these are employed in the

participants' interaction. Table 5.2 presents a selected list of prominent metaphors used by various health professionals in the counselling sessions before presenting selected examples of their usage in actual talk.

Table 5.2 Metaphors used during counselling

Notion in English	**Chichewa Metaphor**	**Translation of Metaphor into English**
penis	*chida* *katundu*	tool items or goods
cervical membrane	*nsengwa or sefa*	winnower or sieve
condom	*chishango*	shield
menstruation period	*nthawi yosamba*	bathing season
accumulated white substance in the foreskin	*madeya*	crumbs
resuming sexual activity after birth	*kulowa mnyumba*	entering the house
sex	*ntchito*	the work
infected vagina (with syphilis or gonorrhoea)	*njira ya minga*	a thorny path

The notions in Table 5.2, column one, are some words and phrases around sex, human organs and reproductive health which are presented in English in the HIV counselling documents but the health professionals arbitrarily translate these into Chichewa (the language used in counselling). By using different metaphors as euphemisms, the health professionals seem to translate the terms in a way that is representative of their individual way of thinking and seeing (Lakoff and Johnson, 1980), and also according to group or cultural interpretations. Some of the metaphors in Table 5.2 are subjective and descriptive, such as "tool", "crumbs," "thorny path," or "items" which seem to be arbitrarily employed by the speakers (some of them were used only once and by no more than one speaker). As the participants translate their ideas into more familiar and concrete forms using different metaphors, they provide an "interpretive frame" that each speaker has (Hilligoss, 2014: 120). On the other hand, metaphors such as "entering the house" and "bathing season" seem to have a cultural connotation relating to the custom

of breaking a separation season between husband and wife during prenatal and postnatal periods; and rituals associated with cleansing during menstruation periods for women respectively. These two metaphors are "within-group metaphors" (Rolf, 2009: 164) which were used with a presupposed group knowledge. As the health professionals used such metaphors they did not have to explain what they meant by such phrases but knowledge was presupposed.

Example 5.3 illustrates ways in which the use of metaphors contributed to the interpretation of medical knowledge and facilitated negotiation of knowledge among the participants. Two activities are happening in Example 5.3, a woman seeks clarification on a piece of information, and the health professional uses common linguistic resources to respond to the question.

Example 5.3: Clarification by using metaphors

Context: A female counsellor (HP1) talks to a group of 15 women attending antenatal clinic. At this point he talks about the dangers of HIV to a pregnant woman, the treatment that an HIV infected woman receives from the hospital, and the importance of delivering at the hospital.

1	HP1:	*Pali funso tisanapitirize?*
	HP1:	Is there a question before we proceed?
2	W6:	*Mmm*
	W6:	Mmh
3	HP1:	*Funsani*
	HP1:	Please ask.
4	W6:	*Mwanena kuti mmene tililimu tikhoza kumpatsira mwana amene*
	W6:	You have said that in this state we can infect the baby we are
5		*tikuyembekezerayo (.) chikhaliremo mwana amakhala ndi thumba*
		expecting (.) yet the baby is in his or her own sac (.)
6		*lake (.) zingatheke bwanji?*
		how is this possible?
7	HP1:	*Alipo angathe kutithandiza funsolo?*
	HP1:	Is there anyone who can assist us with this question?
8		*Akuti mwana timamva kuti ali muchithumba mwake (.)*
		She says we hear that the baby is in his or her own sac,

9		*amayi ampatsira bwanji mwana kachilombo oti ali*
		how can the mother infect the baby with HIV yet he or she is in
10		*mukathumba mwake? Angatithandize ndani kuyankha funsolo? (7)*
		own sac? Who can assist us in responding to the question? (7)
11		*Chabwino (.) chimene chimachitika nchonena kuti (.)*
		Alright. What happens is that (.)
12		*azimayi timakulimbikitsani kuti muziyamba sikelo*
		we encourage you women to visit the antenatal clinic
13		*ndi miyezi itatu eti?*
		within the first trimester, right?
((omission of 13 lines, she talks about the importance of starting antenatal visits early and explains what happens during each visit before returning to answer the question))		
14	HP1:	*Munamva kuti °"mayi woyembekezera chitetezo chake*
		Have you ever heard that ° "a pregnant woman has
15		*chimakhala chotsika?" °*
		low immunity?" °
16	W:	*Mmm*
	W:	Mmh
17	HP1:	*Tikakhala kumudzi timati °"chifukwa choti akugawana ndi mwana*
		In the villages we say, "It is because she is sharing her blood
18		*magazi akugawana ndi mwana"°(.) Timatero eti?*
		with the baby they are sharing" (.) That is what we say, right?
19	W:	*Mmm*
		Mmh
20	*HP1:*	*Chitetezo cha mayi woyembekezera chimakhala chotsika*
		The immunity of a pregnant woman is usually low
((omitted 35 lines, during which she explains what happens in the body and the attention given to a pregnant woman at various antenatal visits to protect her from illnesses))		
21	HP1:	*chomwe chimachitika ndi chonena kuti (.)*
		What happens is that (.)
22		*mwana inde amakhaladi mthumba mwake (.)*
		the baby is indeed in his or her own sac (.)
23		*koma tonse timadziwa kuti mayi amakhala ndi timati cha?*

		but we all know that the mother has what we call
24		*nsengwa eti?*
		a winnower ((cervical membrane)), right?
25	W:	*mmm*
	W:	mmh
26	HP1:	*Nsengwa, nsengwa ija imagwira ntchito ngati sefa (.)*
	HP1:	The winnower (.) the winnower functions as a sieve (.)
27		*imasefa zoyi:pa kuti zisapite kwa mwana.*
		it sifts the ba:d things so that they do not pass to the child.
28	W:	*Mmm*
	W:	Mmh
29	HP1:	*Zipite zabwino zokhazokha (.)*
	HP1:	Only the good things should pass (.)
30		*sefa ikabooka chimene chimachitika ndi chani?*
		What happens when a sieve is worn out?
31	W7:	*Imatulutsa ndi zoipa [zomwe*
	W7:	It releases the bad bits [as well].
32	HP1:	[*Imatulutsa ndi zoyipa zomwe*
	HP1:	[It releases] the bad bits as well.
33	W:	*Mmm*
	W:	Mmh
34	HP1:	*Nde mayi ali ndi HIV, kuyembekezerako kukumutsitsa chitetezo,*
	HP1:	so the mother has HIV, the pregnancy is reducing her immunity
35		*HIV ikumutsitsa chitetezo, ndiye abwere kaya ndi malungo,*
		HIV is reducing her immunity, so if she suffers from malaria, that
36		*amutsitsanso chitetezo (.) ndiye kuti nsengwa ija imayambano*
		will also reduce her immunity, it means that the winnower starts
37		*kugwira ntchito ngati sefa yobooka (.)*
		to function as a worn out sieve,
38		*imakhala kuti panthawi imene mukudwala ija*
		it happens that as you are ill
39		*imakhala ilibe mphamvu [yoteteza kuti-]*
		it no longer has the strength [to protect the-]
40	W:	[(∧∧∧∧∧)]
41	HP1:	*mwati bwa?*

		What did you say?
42	W8:	*Imayipitsa (∧∧∧) kunkhani ya sefa ija*
	W8:	It spoils a lot (∧∧∧) on the issue of the sieve.
43	HP1:	*Eee, imakhala kuti nsengwa ija ikugwira ntchito ngati sefa*
	HP1:	Yes, it happens that the winnower is functioning as
44		*yobooka (.) eti?*
		a torn sieve (.) right?
45	W:	*Mmm*
	W:	Mmh
46	HP1:	*Nde kuti inunso chitetezo choti mumuteteze mwana uja*
		And it means your bodily immunity that should protect the child
47		*kuti musampatsire HIV panthawi imene ija chimakhala kuti palibe,*
		from HIV at that time is lost,
48		*nde HIV ikhoza kudutsa kupita kwa ndani?*
		so HIV can pass and go to who?
49	W:	((ena)) *kwa mwana*
	W:	((few)) to the baby
50	HP1:	*kwa mwana mosavuta (.) Tili limodzi?*
	HP1:	to the baby easily (.) Are we together?
51	W:	*Eee*
	W:	Yes

In a few cases the women did not just respond to the health professionals' questions but they also asked questions. In Example 5.3 above, as HP1 talks about transmission of HIV from mother to the unborn child, one of the women asks a question seeking an explanation about how it happens (lines 4-6). The woman's question has three parts: she begins by repeating what HP1 said which suggests that she has been following the presentation and she presents her general knowledge on the reproductive system as she seeks clarification on how transmission occurs. This suggests a very active engagement where she not only grasps declarative knowledge (about what happens), but she evaluates the new knowledge and relates it to what she previously knew.

Following the woman's question HP1 does not directly respond to the question but asks other women to respond to the question (lines 7 and 10) perhaps to check their knowledge on this. Just like in pedagogic discourse (Bernstein, 1996), she engages the

rest of the women in sharing their knowledge about the concept in question. When no one else responds, perhaps due to the technical nature of the question, she proceeds to give them her answer. Her answer to the question turns out to be lengthy (covering about 50 lines) signifying that ensuing from the woman's question is more information to be delivered.

The health professional responds to the question by drawing from what the women might already know "Have you ever heard that the pregnant woman has low immunity?" to which the women give a positive response (lines 14 and 15). Although she does not mention the source of this knowledge it presupposes that women have other sources of information besides the healthcare centre (see section 5.3.2 for a detailed analysis on presupposed knowledge). By referring to a lay person's way of explaining the phenomenon of reduced immunity in pregnant women, for instance, she ventriloquises a woman's voice in a soft speech "in the villages we say, 'it is because she is sharing her blood with the baby they are sharing,' that is what we say, right?" (lines 17 and 18). By saying that, she demonstrates that the indigenous explanation (lay knowledge) and medical explanation in this case are related. She builds the medical explanation (line 20) upon the lay knowledge. Her statement also suggests a shared (local) knowledge with the women and it is reinforced by her use of the collective pronoun when she says "in the village we say" (line 17). With such common references they construct a mutual source of knowledge and common social practices, while the health professional identifies herself as one with the women (Fisher, 1991; Gordon, 2003).

In addition to the presupposed shared knowledge, she also utilises local knowledge in the form of metaphors to describe HIV transmission and the associated organ, the cervical membrane. The use of *nsengwa* (winnower) as a metaphor for cervical membrane and *sefa* (sieve, as an extended metaphor) with a metaphorical explanation may present an easier understanding for the women. In this case the health professional has made a clear conceptualisation of the metaphorical expression that she has used to relate the source and the target domains. Other scholars have shown that in terms of identification of metaphors in analysis it may not be so straightforward, the "boundary between literal and metaphorical language" can sometimes be fuzzy (Semino et al., 2004: p1277). Use of *nsengwa* (winnower) as a translation for cervical membrane appears to be standardised language across the clinic because more than one participating health professionals used it in their talk. The original use of the metaphor

"*nsengwa*" was not shown anywhere in the documents because they were all in English, with the term cervical membrane in use. This may suggest that *nsengwa* is a metaphor used by the health professionals in the clinic to translate cervical membrane into the local language, Chichewa. The term *nsengwa* is portrayed as a rich metaphor whereby HP1 creatively adds an explanation, and adds an extended metaphor '*sefa*' (sieve). This is a form of intertextuality whereby the everyday language is utilised in the medical context. By using the metaphor with an explanation she recontextualises what the experts (such as what was observed from standard usage of the metaphor by other health professionals in the clinic) would say and utilised much more detail to suit the non-expert audience (see Semino et al., 2013).

Winnower and sieve are common kitchen utensils that almost every household in Malawi owns, these two utensils are essential for the preparation of Malawi's staple food, *nsima*. *Nsima*'s only ingredient is corn flour which is locally milled in communities and the processing of corn starts at household level with a winnower as a main utensil for sifting. This locally milled flour tends to contain some lumps and use of a sieve is deemed to be essential.

By mentioning utensils whose uses the women can easily identify with, the health professional managed to get to the level of women's understanding. The women's responses at the end of her explanation suggests that they got the point; there is a strong affirmation "yes" (in line 51) and frequent minimal responses throughout her explanation such as, "mmm" (lines 19, 25, 28, 33 and 45). Moreover, when HP1 asks them what the sieve does (in line 30) one woman explains without hesitation that "it releases the bad bits as well" (line 31) in a way that contributes to the construction of the intended meaning, which is confirmed by HP1's repetition of the woman's answer (line 32).

One of the women demonstrates a further level of engagement by interrupting the health professional with a comment (line 40). She responds to the relaxed environment afforded by the sharing of cultural knowledge by commenting without waiting for a turn cue to speak as one would do in a formal encounter. When asked to repeat (because her speech overlapped with HP1's) she admits that she was just adding to what HP1 was saying (line 42), a sign of her voluntary engagement in the discourse. HP1 seems encouraged by the woman's level of participation as she strongly agrees with the woman and proceeds to explain further (lines 43-44) thereby facilitating a form of

collaboration among them. By giving verbal listening cues and comments the women support HP1 in continuing with her long explanation and prevent potential monotony in the talk.

The choice of metaphor and taking time to explain illustrates creativity for the health practitioners, i.e. utilising language that is relevant to the context (e.g. Semino et al., 2013). Skelton et al. (2002) studied metaphor from the perspective of health practitioners, such as of GPs in the UK, and observe that patients use metaphors differently from medical practitioners. The health practitioners used metaphors that were linked to power or those that positioned them as problem solvers or controllers, e.g. 'repair', 'system' or 'control' (e.g. Skelton et al., 2002: 116). They also showed that health professionals may build on or use patients' metaphors to reinterpret what the patients' say as they narrated their problem. In a study by Semino et al. (2004) of interpretations of metaphors, they analyse corpora on cancer consultations and show how health practitioners used metaphors, e.g., the development of cancer conceptualised as a 'journey' (p. 1279). Such studies show that metaphor has a vital function in expressing illness experiences and meaning. The metaphors and simplification used above exemplify local knowledge on the part of the health professional that facilitate a shared meaning among the members in terms of the source and target domains of the metaphors.

In Example 5.4, HP4 combines metaphor and story-telling to clarify his point. There were several instances where health professionals resorted to narrating stories for clarification of points; some of the narratives were: an analogy of a person ready to fight an enemy to signify the importance of knowing one's HIV status; another was about a person who falls into water because he was moving without looking where he was going. Example 5.4 illustrates how one health professional tells a story as an analogy to simplify numbers for a potentially technical presentation.

Example 5.4 Simplifying technical information

Context: A male counsellor (HP4) is talking to a group of 16 pregnant women during and antenatal visit. In this extract he talks about voluntary male circumcision as an HIV prevention strategy.

1	*HP4:*	*Komanso mdulidwe paokha (.) umatha kuteteza kufala*
		Also, circumcision alone can reduce the spread of
2		*kwa HIV ndi 60 percent*
		HIV BY 60 percent.
3		*Tingotenga ujeni mm uyu*
		Let's take this er er this
4		*>akhale gule ameneyu wa kwa Joni<*
		>let's refer to this as a dance by John<
5		*nanga sitimati kwa Joni ee kubala ndiye kwa Joni eti?*
		don't we say John, yea John's seed yea? Right?
6	W:	*Eee*
		Yes
7	*HP4:*	*Hule uja ali ndi kachilombo ka HIV*
		This prostitute has HIV
8		° *nde tiyerekeze panopa ma gu- anyamata ten*°
		°suppose there are ten gu- boys here °
9		*mwina tatopa tinali kundende (.)*
		maybe we are tired because we were in prison (.)
10	*W:*	*Mmm*
		Mmh
11	HP4:	*tonse osadulidwa (.)*
		We are all uncircumcised.
12		*Nde tikufuna kugona naye amene ujayo eti? (.)*
		So we want to have sex with this one, right? (.)
13	W:	*Mmm*
		Mmh
14	HP4:	*Zitha kutheka kuti mwa anthu ten akugona naye amene uja*
		It is may be that among the 10 people who will sleep with her
15		*anthu tonse tikhoza kutenga kachilombo ka HIV (.)*
		all of us can contract HIV (.)

16		*kupaturapo munthu mmodzi eti?*
		except one, right?
17	W:	*mmm*
		Mmh
18	HP4:	*Sichoncho eti? Nde zitha kutheka kuti apapa tilipo anthu (.)*
		Not so? So it is also possible that there are (.)
19		*okwanira angati? (.) Okwanira ten eti? (.)*
		how many of us? (.) Ten of us, right? (.)
20		*oti tinadulidwadulidwa*
		all of us circumcised
21		*>monga mmene aliri akulu amene tawatsekera mkatimo<*
		>just like the gentleman in the drawer over there <
		((referring to a model of a penis))
22	W:	((ena)) *Ee*
	W:	((few)) Yes
23	HP4:	*>kaya mbokosi kaya muchani?<*
		>is it a box or what?<
24		*Nde:: kugonana kwa amene aja kupezeka kuti*
		So the ten people's sexual activity
25		*kupezeka kuti pa anthu ten aja*
		it will be found that the ten people
26		*apeze::ka anthu siki:si oti satenga kachilombo ka HIV*
		may resu::lt in six not contracting HIV
27		°*pamene anthu folo akhoza kutenga kachilombo° eti?*
		°while 4 people may contract HIV° right?
28		*Mwaona pamenepo tachepatu eti?*
		You see that we have been reduced right?
29	W:	*Eee*
	W:	Yes

In Example 5.4 HP4 uses metaphorical language and narrates a fictional story to explain the statistics pertaining to the effectiveness of male circumcision in the prevention of HIV infections. He uses a fictional example of 'John's dance' as a metaphor for sex and uses it to tell a story (lines 2 to 3). By making a reference to "a dance by John" (lines 4

and 5) as a culturally familiar metaphor for sexual intercourse, and "John's seed" as the resulting offspring. The women confirm this metaphor and show that they understand what he means by giving him a strong agreement "yes" (line 6) when he asks them "that's what we say, right?" (line 5).

HP4 uses a simplified example in a story to explain the numerical and technical concepts. By using simpler details, for instance how six people out ten may end up contracting HIV rather than simply stating 60%, is deemed to be clearer for the women in this context. The presentation of a percentage (in lines 1 and 2) may be simple but to this group of women in this context, where literacy is an issue, such a simplification might be required. For instance it was noted that out of 37 women that were interviewed, only five had attained a level of education higher than primary school, the rest dropped out at junior primary level and two said they did not go to school. Thus, the story "reframes" the statistics into a palatable form (Tannen and Wallat, 2006).

It is also observed that the story helps to create a more relaxed atmosphere as it brings the health practitioners' and patients' worlds closer and with the story functioning as the medium that takes both sides to a familiar world (Bleakley, 2005). The relaxed atmosphere is manifested when the women give HP4 responses (lines, 10, 13 and 17), even where he does not clearly construct a turn for them, they continue to grant him responses (in lines 9-10) to show they are following the story and they do so consistently to the end of the narration. This is an indication that they are following the explanation in the story as it may stimulate their imagination in the depiction and description of a scene (Clark and Van Der Wege, 2015) more than what an ordinary presentation of this numerical information would do.

HP4 draws from contextual aspects that all can understand: those of the 'prison' and the 'prostitute' (lines 7, 8 and 9). His choice of actors is typical of HIV discourse in this context, 'prisoners' because of homosexuality, and 'prostitutes', being constituted as the most vulnerable category of subjects in the HIV/AIDS discourse (Breitinger, 2011). By using this simplified language, the health professional enters into the world of a layperson, to present meaning (Candlin, 2006). By telling the story he appears to change from the typical institutional framing of seriousness to a more conversational one (Ribeiro, 1996). Mostly narratives in health care are told by patients, whereby physicians make sense of patients' conditions from their stories and most discourse studies have looked at patients' narratives (Heritage and Robinson, 2006; Hunter,

1991). One study analysed the presentation of patients' cases by physicians, in their professional meetings, as a form of narrative (Hunter, 1991).

In addition, the sets of knowledge in this talk suggest an overlap between medical and local knowledge. The health professionals are members of the same social community that the clients belong to, and – although they have access to expert knowledge – they are also familiar with this other world. In addition, as HP4 tells the story this way, it conveys empathy because, despite having power as a knowledgeable health professional, he takes time to explain the scenario (Bleakley, 2005), and explains in a dramatic way where he includes himself as one of the men in the story thereby almost bringing himself on a lower footing closer to the women. In this respect, he constitutes a double identity – of 'health professional' and 'co-member of the community' – with the women simultaneously. On the other hand, he negotiates lay knowledge and expert knowledge as he reproduces the knowledge in a form that the women can grasp (e.g. Gülich, 2003).

The section has demonstrated how various resources are drawn together to produce collaborative meaning in the texts. Metaphors and narratives perform a central discoursal function in the talk in that by using these resources the participants construct an in-group and assume a shared context of sense making (Gordon, 2003). There is clearly an attempt by the participants in the texts to draw from different types of knowledge and reproduce them in this context (see MacDonald et al., 2009).

The health professional and the clients may share knowledge in some cases; however, there are times when the health professional's presupposed shared knowledge is rather too technical. The next section discusses how the interlocutors referred to other texts to negotiate cultural or 'shared' knowledge sources.

5.3.2 Common (or not so common) knowledge

There were instances when the health professionals and the women's interaction revealed a negotiation regarding whether certain information was well known among them or not. Some of the health professionals appeared to presuppose some common ground knowledge about HIV/AIDS between themselves and the clients' discourse (e.g. van Dijk, 2002) and in some cases they also attempted to refer to other forms of discourse, i.e. of the radio, church and community meetings. In Fairclough's argument, this is a form of 'intertextuality' in which texts draw upon other prior texts (1992: 39, after Kristeva, 1980). This intertextuality reinforced the existing presupposition of the health professionals as they suggested that they and the clients acquired their knowledge from the same sources. With reference to Example 5.5, this section explains how the health professionals and the women negotiated the presupposed knowledge during their interaction.

Example 5.5: Intertextuality in the talk

Female counsellor (HP1) talking to a group of 14 pregnant women attending antenatal clinic, at this stage they are talking about transmission of HIV.

1	*HP1:*	*Ndeno pali njiranso ya amayi yopatsira mwana wodzabadwa (.)*
	HP1:	and there is another way the mother transmits it to the baby.
2		*ndili ndi chikhulupiriro kuti njira imeneyi mukuyidziwa eti? (2)*
		I believe that you know this way right? (2)
3		*Njira ya amayi kupatsira mwana odzabadwa (.)*
		the one where the mother transmits it to her baby (.)
4		*Tinamvapo zanjira imeneyi? (3)*
		Have we ever heard about this way? (3)
5		*Pawayilesi <u>amanena</u> (.) Njira imeneyi tinamvapo? (4.5)*
		It is mentioned on the radio. Have we ever heard of this one? (4.5)
6		*<u>Azimayi</u> chetechete sautsa nyama nonsenu nang=*
		Ladies, hunters' silence cannot stir the animals, all of you hav =
((a proverb literally translated; meaning silence cannot bring results))		
7	*W2:*	*=sitinamvepo*
	W2:	=we have never heard of it
8	*HP1:*	*°Ena? ° Sitinamveponso?*

	HP1:	°What about others?° We have also never heard of it?
9	*W:*	*((ena)) mmm*
	W:	((few)) Mmh
10	*HP1:*	*Tonse tili apa sitinamvepo kuti amayi akakhala*
	HP1:	All of us here have never heard that when a woman has
11		*ndi <kachilombo ka HIV akhoza kumpatsira mwa:na?>*
		<HIV she can transmit it to her chi:ld?>
12	*W:*	*((two)) Tina[mva]*
	W:	((two)) We have [heard it before.
13	W:	((*ena)) [Tinamva]*
	W:	*((few))* [we have heard it before]
14	*HP1:*	*Tina:mva. Amene tinamva ife,*
	HP1:	We have hea:rd it before. Those of us who have heard it before,
15		*<tinamva kuti zimakhala bwa:nji?> (6)*
		<from what we heard, what happe:ns?> (6)
16		*Amene tinamvafe tiagawireko anzathu*
		Those of us who have heard this, let's share with our friends
17		*eti? Zimene tinamvazo, tinamva kuti zimakhala bwanji? (2)*
		right? From what we heard, what happens? (2)
18		*Mayi wanga (.) talongosorani?*
		My lady (.) please explain?
19	W*3:*	*Mm he he ((kuchita ngati kuseka))*
	W3:	Mh heh ((chuckles))
20	*HP1:*	*(8) Tikugawanatu nzeru,*
	HP1:	(8) We are simply sharing insights here,
21		*°zochepa zomwe mungafotokoze ena atengapo,*
		°what ever little you can explain someone will learn something,
22		*ziathandiza eti?° Eee (.)*
		it will help them, right? °Yes (.)
23		*Nanga adona pamenepo inu munamva kuti chani? (6)*
		What about madam over there, what did you hear about this? (6)
24		*Chabwino eti? Amayi akhoza kumpatsira mwana kachilombo*
		Okay, right? A mother can transmit
25		*ka HIV munjira zitatu (.) tili limodzi eti?*
		HIV to the baby in three ways (.) we are together right?

26	*W:*	*Mmm*
	W:	Mmh

Example 5.5 opens with an explicit reference to other contexts and in this way the health professional implies that the hospital setting is a site of reproduction of knowledge. The women are asked to reproduce knowledge "from what (they) have heard" (line 17). This is evidence that what is heard from one genre (i.e. radio, community outreaches, interpersonal encounters) is shared in the current setting (Hodges, 2015). The reproduction of knowledge obtained from other media is also evident in how sentences were sometimes structured by the women as they responded to the health professionals' questions elsewhere, for example, "why is it important to have an HIV test when pregnant?" was usually responded to in a similar manner, "to know how your body is…" by different clients in different sessions and during interviews. This statement may be taken from a popular slogan in the promotion of voluntary HIV testing, "knowing how your body is, is better than not knowing" (from Malawi radio and posters on promotion of HIV testing). The clients seem to draw HIV discourses from one context (e.g. radio) and reproduce them in the current setting. Similarly, during interviews the women mentioned village meetings, radio, and community health outreaches as their main sources of HIV/AIDS information.

As HP1 checks the women's knowledge in Example 5.5, she sounds certain that the women know how transmission from baby to mother occurs, "I believe that you know this way right?" (line 2). The women do not answer despite the repetition of her question with invariably long pauses as she waits for an answer (lines 4, 5). Although she mentions a potential source, with a matter of fact tone "it is mentioned on the radio" (line 5) and pauses again, the women did not respond. Anticipating that the women have knowledge on the issue, she pleads by employing a common Chichewa proverb *chetechete sautsa nyama* (line 6), which is literally translated as hunters' silence cannot stir the animals, meaning that you cannot get any results by being silent and not acting. There was no need for her to elaborate the proverb, as the meaning seems shared by the participants when one of them immediately interrupts HP1 with her response (with a latch between lines 6 and 7) that they have never heard of how it happens.

It is believed that the health professional presupposes some shared knowledge with the women. Despite the woman's negative response (line 7), HP1 is sure that they might

have heard of it for she persistently checks if all of the women had no idea and never heard that a woman can transmit HIV to a child (line 10). Until she repeats the information that they are referring to, "all of us have never heard that when a woman has HIV she can transmit it to her child?" (line 7), two women tell her that they heard of it, followed by a few other women who echo the response "we have heard of it before" (lines 12 and 13) which confirms that most of the women had heard of it before. Their lack of an answer may occur not because they do not know that transmission of HIV from mother to child occurs but they may find it difficult to explain the process as demanded by the technical nature of the question "what happens?" (line 17). The women are willing to speak up but seem to have difficulty in explaining the technicalities of what happens and how it happens, despite being repeatedly asked to explain (lines 14 and 17) which results in several pauses in the extract with the longest being 8 seconds (line 20).

As the conversation progresses HP1 specifically asks one woman to explain what she heard (line 18) but the woman simply gives a chuckle (line 19) which suggests some difficulty in giving the answer. After several attempts HP1 proceeds to deliver a detailed explanation about how HIV passes from mother to child while in the womb which sounded rather more technical than common medical knowledge. Her explanation, in my opinion, was one that could not be remembered easily by a lay person because it was too technical (line 24ff not shown here). Thus, the health professional encourages the women to reproduce their declarative medical knowledge about HIV/AIDS in a way that has proven to be a challenge for the women. This signifies a distinction between non-specialised medical knowledge (shared with the women) and specialised medical knowledge, in this case of the health professionals (e.g. de Kok and Widdicombe, 2010). In turn, the participants discursively construct the divide between the expert and non-experts.

By raising different opinions (we have never heard of it" and "we have heard of it"), the women are involved in the talk and signify their agency in the talk to negotiate what is common-ground knowledge and what is not. In addition to this they also construct a perspective: not every information about HIV/AIDS that is broadcast on the media is well known by the women (e.g. "we have never heard of it", line 7). The women are therefore not passive, but are possibly recalling information that they access from different sources. Furthermore, the women have contributed to the discourse by showing that they are willing to share their knowledge with HP1 but they also have

some knowledge limitations. The participants have jointly constructed the notion that there is some 'not so common' knowledge, hence indicating the importance of this counselling talk. In this respect, the healthcare centre is not only a site for the reproduction of shared and basic knowledge about HIV, but it is also constructed as a site for obtaining new knowledge, especially of the technical type, which may not be available in other sites where the women interact with health information. This interaction reinforces knowledge differentials between the experts and non-experts in which the women's lay knowledge and the health professional's expert knowledge is reflected, in the end it accords HP1 some form of "symbolic control" (Sarangi and Roberts, 1999: 8).

In addition to the instance of encouragement in Example 5.5 above, in Example 5.6, there is explicit intertextuality as the health professional makes reference to other potential genres of discourse in an attempt to help the women recall some information. As they are involved in some form of negotiation of this presupposed knowledge, i.e., what is implied as common-ground knowledge (van Dijk, 2002) they define their shared source of knowledge.

Example 5.6: Sources of knowledge

Context: Female counsellor (HP1) and 15 pregnant women during antenatal visits. At this point they are talking about protecting oneself from HIV infections.

1	HP1:	*Eee nde ndikufuna kuti inuyo muyambe mwadziteteza*
	HP1:	Yes, So I would like you to protect yourselves first
2		*kenako tione kuti kodi mwanayo mumteteza bwanji (.)*
		and then we should see how you should protect the baby (.)
3		*Tadzitchulani njira zina zimene inuyo mungadzitetezere (8)*
		Mention other ways that you can protect yourselves. (8)
4	*W5:*	*°Nkutheka tayiwara° mungotikumbu:tsa*
	W5:	°It is possible we have forgotten°, may you just remi:nd us.
5	*HP1:*	*Mmm: Mmm: Ado::na zili masiku ano °pa radio,*
	HP1:	mh:: mh:: Mada::m, these days it is all over, °on the radio
6		*zikunenedwa, m'matchalitchi zikunenedwa°*
		they talk about these, in churches they talk about these°
7		*mmisonkhano yosiyanasiyana:: zikuta:ni? (2)*
		in different meetings:: they what? (2)
8		*°zikunenedwa (.) eti?° Amayi anga?*
		°They talk about this (.) right? °My lady?
9		*<Tandiuzeni njira imodzi imene mungadzitetezere <u>inuyo</u>?>*
		<may you tell me one way that you can protect <u>yourself</u>?>
10	*W8:*	*>Tayiwara zinazo<*
	W8:	>We have forgotten the other ones<
11	*HP1:*	*Mwayiwa::ra?*
	HP1:	You have forgo::tten?
12	W:	*mmm*
	W:	mmh
13	*W:*	*((ena)) Heh heh((ena akuseka))*
	W:	((some)) Heh heh ((others chuckle))
14	*HP1:*	*Nanga pa cornerpo, Achemwa? (12) Taziyankhanitu:: (3)*
	HP1:	What about from that corner, sister? (12) Please answer:: (3)
15		*<u>Chabwino</u> (.) njira zina zilipo zambiri…*
		<u>Alright</u> (.) there are other many ways…

In Example 5.6 the health professional (HP1) presupposes that the radio is a common source of knowledge about HIV, and by referring to the radio she encourages the women to develop their knowledge from what they hear from other sources. In the talk (Example 5.6) references are made to other knowledge sources in an effort to encourage the women to give the health professional answers to the questions (lines 1-3). Prior to this excerpt they had discussed different ways of protecting oneself from HIV infections, the women mentioned commonly known prevention strategies such as, not sharing razor blades, and using condoms, among others; but as the health professional continues to ask the same question for more responses the women did not know what to say. In this instance the women indicated that they could not recall more information, although they initially actively responded to the questions. The women's lack of response illustrates that HP1 requires technical information which is either not easy for them to recall or it is beyond their knowledge.

Example 5.6 illustrates that the women continue to show that they do not know the response to her technical questions but they are not deterred to respond that they have forgotten (lines 4 and 9). The woman who says that she has forgotten (W5, line 4) was observed to be active in responding to the questions prior to this stage. Moreover, the friendly atmosphere created encouraged other women to respond in a similar way without fear that the HP1 will perceive them negatively (e.g. W8, line 10). Even after such responses the women laughed in reaction to each other's answers "we have forgotten the rest" (lines 10 and 13). By admitting their lack of answers to the question, in which they use "forgotten" rather than "don't know", it indicates a level of involvement in the talk, i.e. that an answer could have been possible but it's out of reach. Particularly, the women are agentive when they explicitly indicate that they had forgotten and request the health professional to remind them (lines 4 and 10), a request which constructs the health professional as an expert who has the task of delivering the information to the women.

In this example, the health professional also depicts an effort to relate with the women, (see Zayts and Schnurr, 2013). She uses various forms of addressing the women in the talk in order to engage them in sharing what they know. These forms of address signify her effort to respect the women and consider them important to her talk. In the excerpt she uses different terms of addressing the women, perhaps to create a sisterhood for the group. For example, in the introductory phase of the talk the health professional (HP1)

presents herself with familiarity to the women, “I am your usual HIV counsellor and health advisor…” similarly in Example 5.6 she continues to address the women with familiar terms, “my lady” (line 8), “sister” (line 12) and a respectful term, “madam” (line 5). How one addresses clients in medical discourse is said to be a “strategy of involvement” (Gleeson, 2009: 219) because such polite forms of address may show the interest that a health professional has in the clients, (as opposed to the use of ‘you’). It also reinforces in-group membership (Gleeson, 2009), especially where relational terms such as ‘sister’ are used.

The women’s response also constructs the kind of information that the health professional elicits as new to them. HP1 reminds them of the common sources of the information (lines 5-7), and insists that the women should respond to the questions by explicitly raising her presupposition that the information is “all over” (lines 5-7). The women try to recall the information but they do not have answers. This difficulty is signalled by long pauses following HP1’s questions and before the women’s responses are given (lines 3 and 14). HP1 attempts to make the women refer to other sites of knowledge, thereby presupposing that the women have the knowledge, and that they have interacted with these other knowledge sources.

From HP1’s statements, it can be seen that the participants in this site build their talk from various knowledge sources thereby enabling reproduction of knowledge to take place during their interaction. There is a degree of explicit intertextuality whereby the health centre talk draws from the radio and community interactions as other health educational sources, i.e. “drawing upon established genres to frame their discourse, engage with words that have come before them …” (Hodges, 2015: 43). HP1, in this particular instance, seems to be using a combination of sources, the expert and medical knowledge from their medical training and books as well as from various community sources that are shared with the women. The clients have obvious differences with the health professionals in terms of their access to knowledge as well as the sources but the participants possess a certain shared “cultural and social capital” along with the women (Brown et al., 2006: 13).

This section has therefore illustrated how the women’s responses to some of the health professionals’ questions categorises knowledge that was commonly known and that which was technical, therefore, not so common for the women. It has also shown how, by repeated questioning and reference to other sources, some of the health professionals

construct the reproduction knowledge as the activity of group counselling in this site. But this is done in varying degrees. As shown earlier, experience or level of expertise differs from one health professional to another, which can also affect their communication strategies (e.g. Sarangi and Gilstad, 2014). Apparently, there is an implicit tension of knowledge when negotiating technical and group knowledge about HIV in the given examples. Some of health professionals, for instance HP1, seem to have a weak realisation of the distinction of what constitutes common group medical knowledge and technical knowledge. Consequently, the women's participation in the reproduction of the commonly shared knowledge about HIV/AIDS is sometimes undermined, which leads to awkward moments for the women as they admit their forgetfulness or lack of ideas (e.g. line 9, Example 5.6) in the talk.

5.4 Chapter conclusion

The chapter has analysed several interactions that took place between health professionals and the clients to demonstrate that the HIV group counselling talk is organised around providing an opportunity for clients to reproduce various types of knowledge that have been sourced from elsewhere. Use of different types of question and answers – in the format of an interview – is the common strategy which the health professionals utilise to give the women an almost equal number of turns to speak alongside themselves. The question and answer format is also a strategy that has been used to appropriate how knowledge about HIV/AIDS is to be reproduced (or how HIV/AIDS is to be talked about).

The women's way of responding to the questions shows that different formats of questions enabled them to explore different types of knowledge (medical and sometimes group knowledge). The women negotiated these different knowledge types as they responded to the questions, thereby being constructed as collaborators alongside the health professionals in this discourse.

The chapter has demonstrated how the women and the health professionals were agentive in negotiating different forms of knowledge. By using local and shared knowledge alongside medical knowledge in negotiating the meaning of technical terms, the participants in the context of this study have demonstrated a relationship between local knowledge and expert or medical knowledge (Examples 5.3 and 5.4). In some

cases, however, one of the health professionals' extended presupposition of common or shared knowledge with the women led her to ask complicated questions that challenged the women's agency in the talk (Examples 5.5 and 5.6). Additionally, the demands of some questions seem to move beyond the basic knowledge that could be reproduced by the women in this context, which constructs the sessions as a context for active negotiation of knowledge forms.

It can, however, be said that negotiation happens but only to a degree. There are moments when there is active negotiation when the women initiate, and resist with comments and laughter, which is where there is an assertion on the part of the women, but these were exceptional cases. However, the women played a role. The health professionals were not completely dominant and the women contributed to the discussions, making the interaction a more collaborative than a unilateral presentation.

Chapter 6 discusses how some discursive strategies utilised by the health professionals present potential challenges to clients' active participation and reinforce asymmetrical power relations.

Chapter 6: Social structures and power relations in antenatal group counselling

6.1 Introduction

This chapter focuses on knowledge and power relationships among the participants in the counselling interactional data, which are interpreted in relation to the institutional structures in which the talks are embedded. Chapter 4 established that the participants reproduce their knowledge about HIV/AIDS and the health professionals aim at collaborating with the women in their talk; while Chapter 5 (section 5.3) discussed specific discursive strategies that the health professionals use to engage the women in the interaction. Chapters 4 and 5 have shown examples where there are agentive attempts in client involvement as the participants collaborate in the talk, although these vary according to health professional who is facilitating the counselling sessions. There are, however, instances where the ethos of client-participation is inhibited and the women's position as collaborators in the HIV/AIDS discourse is therefore challenged. This chapter follows from the two previous ones to analyse some ambiguities of the health professionals' discursive strategies which, although employed ostensibly with the ethos of increasing client participation, also appeared to reinforce asymmetrical power relationships and orient to the institutional structures in the talk. Although it is claimed that the counselling is conducted within an ethos of client-centredness and clients' informed choice, the participants also orient to power asymmetries reinforced by the social structures, which affect the women's agency to participate in the discourse of HIV/AIDS at the clinic as well at home. Such power asymmetries, in turn, reinforce an element of control by the health professionals on the knowledge that is reproduced during the sessions and the nature of interaction, thereby revealing a link between power and knowledge (e.g. Fisher, 1991; Wodak, 1997). This chapter partly draws from the framework of critical discourse analysis to analyse the interactional data in relation to the broader contextual aspects.

The social structure of the participants in this study is best understood by considering the background of HIV/AIDS and women in Malawi. Women in Malawi are said to be more vulnerable to HIV/AIDS than men, for instance, with 10.8% annual HIV prevalence for women, while that of men is at 6.4% (NSO, 2016). Arguably, the vulnerability of women is due to their lack of autonomy, which is due in turn to their

low economic status and lack of say in sexual matters (Chinkonde et al., 2009; Flax et al., 2017). One study observed that decision making among couples was shared in some cases and situationally dependent but males dominated in areas of sexual relations and those to do with finances (Mbweza et al., 2008) which attests to the vulnerability of women in HIV related problems. Although maternal issues have, for a long time, been traditionally considered women's business (Kumbani et al., 2013), in both matrilineal and patrilineal societies, decisions in accessing modern health care mostly depend upon the male partners (Kululanga et al., 2011; Zulu, 1998).

Additionally, there are power asymmetries that exist in the medical setting where the women infected with HIV may have an unquestioning attitude during interaction with health providers because they look up to the health providers as having the authority and as the only providers of information (Donahue et al., 2012; Penn et al., 2011), but the health providers sometimes have discouraging attitudes, such as being too authoritative and undermining the women (Kawale et al., 2014). This context creates a social structure that positions the woman in a disadvantaged position in the social hierarchy.

The government of Malawi, through various partner agencies, has had to respond to these challenges in a bid to protect babies from infection (Haas et al., 2016; Keehn and Karfakis, 2014; Tenthani et al., 2014) and HIV pre-test counselling sessions are meant to be attended by all women seeking care at the clinic to receive advice and information about prevention, testing, and treatment for infected mothers. Unlike the more collaborative strategies described in Chapters 4 and 5, this chapter discusses instances where the discursive strategies used by the health professionals challenge the women's agency in the talk, reinforce institutional structures and reflect adverse social practices. It should be mentioned here that from the analysed sessions, there were no notable differences in the discourse strategies employed by male and female health professionals in the talk. The chapter opens with an analysis of how medical institutional and social structures, as well as social practices, are oriented to by the participants, and later it explores how within these existing structures the participants negotiate asymmetries of power and knowledge in the talk.

6.2 Social structures and practices in HIV/AIDS discourse

This section focuses on social structures that are reflected in the counselling discourse as well as those that shape the discourse of HIV/AIDS because "there is a dialectical relationship between a particular discursive event and the situation(s), institution(s) and social structure(s) which frame it" (Wodak, 1997: 173). How the clients and health professionals are positioned in the talk produces and reproduces these social structures, and their discourse is in turn produced by these social structures. The link between social and institutional structures and talk in medical encounters has been explored by Waitzkin (1989: 221) who views the micro level processes of medical interaction as occurring "in a social context, which is shaped by 'macro-level' structures in society."

For this study, social structure refers to how various roles of participants are presented in a hierarchy, in terms of their expertise, knowledge, or social roles. These social structures are also linked to institutional structures whereby the health centre as an institution has its own rules, norms or regulations of conduct that may be implicit and explicit to the participants (van Leeuwen, 2008). Social structures are those systems constructed out of encounters between agents in social action, during which status, roles and social stratification are established (adapted from Halliday, 1978). These social structures relate to various institutions, such as family, community or those that are more regulated, such as government agencies, in this case, the clinic. The social structures are "mediated by social practices" (Fairclough, 2010: 74) in the events of the home, the community, and other regulated institutions, such as the hospital.

Thus, in this study, talking about social structures broadly includes all that are actualised in the everyday social events of the people, while institutional structures include those of regulated agencies, in this case, the hospital, the government or global agencies. Structures are transmitted and reproduced socially as the interactants go beyond the current encounter, e.g. of counselling, to reflect a broader situation, such as social practices. Social practices are defined as "socially regulated ways of doing things" (van Leeuwen, 2008: 6) and are formulated by various elements, *inter alia*, participants, actions and location. As patients raise social problems in medical encounters they reflect social structures that define the context of the problems, such as family life, societal roles and social relations (Waitzkin, 1989). The structural contexts of discourse are further understood when attention is given to the "structuring of participation",

interactionally and institutionally, during any social interaction (Sarangi and Roberts, 1999: 2). In the HIV/AIDS counselling sessions, influences of the social structure, institutional structure, and social practices are oriented to by the participants, thereby revealing significant effects on their power relations in the medical encounter.

As stated in the introduction (Chapter 1) the counselling talks are embedded in a context whereby there are some challenges of clients' compliance with HIV treatment, particularly to the recommendations of the PMTCT programme. Example 6.1 illustrates how the social practices are oriented to in the talk by health professionals. The first concept to explicate is how the medical institutional structure is reflected in the talk.

Example 6.1 Expressing institutional effect

Context: A male health professional (HP4) talks to a group of 15 women, the extract is taken from the beginning of a session, at this point he sets the agenda of the talk by stating the aims of having a blood test

1	*HP4:*	*Nde ndi malamulo aboma la Malawi masiku ano*
	HP4:	So it is a current Malawi government regulation
2		*kuti mzimayi wina aliyense amene ali woyembekezera,*
		that every pregnant woman
3		*ayenera kuyezetsa (.) HIV ndi cholinga choti athe kuchepetsa*
		should have an HIV test in order to reduce
4		*kufara kwa kachilombo ka HIV (.) kuchokera kwa mayi kupita*
		the spread of HIV from mother to child
5		*kwa mwana (.) nthawi yoyembekezera eti? (.) Sichoncho?*
		during pregnancy, right? (.) Not so?
6	*W:*	*Eee*
	W:	*Yes*
7	*HP4:*	*Zimene zimachitika ndi zoti mzimayi uja akangoyezetsa*
	HP4:	What happens is that when the woman gets tested
8		*nkupezeka kuti ali ndi kachilombo ka HIV (.) nthawi yomweyo*
		and is diagnosed as having HIV (.) right away
9		*mzimayi uja amatha kumuyambitsa mankhwala a ma ARV eti?*
		they may put her on medication (.) ARVs right?
10		*Samadikiranso kuti apite mpaka awonetsetse chitetezo chawo*

		They no longer wait for screening of her immunity level
11		*chamthupi iyayi (.) ndi cholinga choti athe kuchepetsa*
		No (.) this is done to reduce chances of transmitting
12		*kumpatsira mwana wake kachilombo ka HIV (.)*
		HIV to the baby (.)
13		*panthawi yomwe ali wotani?*
		during the time it is what?
14	*W1:*	*ali wo=*
	W1:	when she is=
15	*HP4:*	*=ali mmimba eti? Komanso panthawi yomwe akubadwa*
	HP4:	=while in the womb (.) right? But also at the time it is born
16		*mzimayiyu akubereka mwana uja amabweranso*,
		when the woman is about to deliver the baby she comes again
17		*mkatikatimonso amabweranso kudzayezetsa, eti?*
		and somewhere along she comes again for another test, right?
18	*W:*	*((few)) Mmm*
	W:	((few)) Mmh
19	*HP4:*	*Amampatsanso <u>mankhwala</u> ndi cholinga choti asadzampatse*
	HP4:	They give her <u>medicine</u> again so that she should not infect
20		*mwana wakeyo ka chilombo ka HIV panthawi yomwe akubadwa*
		her baby with HIV at the time of giving birth
21		*komanso panthawi yomwe akutani (.) akuyamwitsa*
		and during what? (.) breastfeeding.

The extract in Example 6.1 demonstrates how HP4 utilises "intertextual reformulations" (Drescher, 2010:197) of the HIV/AIDS institutional guidelines to emphasise the need for the women to have the HIV test. It could be with the knowledge of the women's diminished status in decision making (reflected in the social practices) that HP4 (in Example 6.1) makes an explicit reference to the government as a regulating institution of the programme (lines 1-5). He does not employ a direct address to the women but seems to bring in another voice, the voice of the government as an institution which he represents, when he says "that every pregnant woman should have an HIV test in order to reduce the spread of HIV from mother to child" (lines 2-5). This is a form of intertextuality whereby HP4 seems to paraphrase statements from HIV testing guidelines and road map for PMTCT (see Appendix 9) to emphasise the need for the women to have the test. For example, phrases on the PMTCT road map which seem to

relate to his statements here are: “Mum HIV-Positive (Exposed infant)” followed by “DBS at enrolment repeat rapid test at age 12 and 24 months”.

As a health professional he appears to mediate between the institution and the women, as he states what is required and what is done to protect both the woman and the baby. This way HP4 legitimises his action of conducting the test by placing it within the institutional structure (Higgins and Norton, 2010). For instance, the use of distant referents “she” and “the woman”, rather than “you” to directly address the women on what they may do, as he describes the various stages that the pregnant woman goes through in relation to HIV treatment (lines 11-12, 15-16), and “they” (lines 9 and 10) to refer to health providers at the clinic (including himself) as actors creates a sort of institutional structure (van Leeuwen, 2008).

By reference to government regulations, (as an institutional authority) HP4 distances the women as co-actors and autonomous decision makers on the action. The woman is constructed as non-agentive (“she” and “the woman”) and as the beneficiary, while the medical institution is situated as the actor when he uses passive forms, such as “the woman gets tested,” “is diagnosed” (lines 7, 8) and presented as non-agentive in “they may put her on medication,” “they no longer wait for her immunity to…” (lines 9, 10). In these statements there is passivation of the woman who is constructed as a receiver of the action, while “they” – the medical institution – is represented with the active role. The government as an external force is construed as “a semiotic agent” initiating the testing, diagnosis, and treatment of HIV to take place (Moore, 2005: 108). This results in the women affirming the statements with verbal responses (lines 6 and 17) and not showing any resistance, consequently all the women in the group took the HIV test.

By employing the objectifying term “the woman,” “she”, “her” and the actor “they” (perhaps the medical institution), and through passivation of the women in the activity, HP4 denies the agency of the women but implies that they are obliged to follow the guidelines and do what is required. This seems to implicitly respond to inadequate compliance to tests and treatment that the programme has faced since its inception (Keehn and Karfakis, 2014; Tenthani et al., 2014), hence the reference to the government and its “regulations” reinforces the government as a regulating agency by which HP4 justifies the need for the women to take test. This choice of terminology at the same time takes away responsibility from the health professional and so he could blame ‘the institution’ or ‘policies’ and justify his deontic responsibilities (see also

Drescher, 2010; Moore, 2005). Using the phrase "government regulation" (line 1) changes the discourse of counselling from that of individual choice to that of compliance (McIntyre et al., 2012) and signals that women as well as HP4 are subject to the authority of the government.

There was frequent explicit reference to the government and medical institution by most of the health professionals to reinforce the need for the women to take the HIV test. This reflects challenges that health professionals may have in counselling, where the medical providers may have a dilemma in dealing with patients where they recognise patients' lack of autonomy in making decisions and the ethos of informed choice, but adopt a directing stance and give their recommendations (Angotti, 2010: 992). In other recorded interactions, some health professionals used verbs that presented no options for the women "that is why we force you to…" (HP1), "you must get tested" (HP3). Since testing is meant to be voluntary (as stated in the HIV testing guidelines), pregnant women do have a choice to opt out. However, by using directive phrases some of the health professionals presented being tested for HIV as a compulsory undertaking for all women delivering at the government hospital, which contradicts the need for autonomy in the women when making an informed decision, while the counsellor acts as a decision maker. From my observations and conversations with the women I learned that some of them were somewhat apprehensive to know their HIV status. In addition, some of the women based their decision to be tested as compliance with the institutional regulation, thereby removing their own agency in the decision making process (Angotti et al., 2011).

From my observations and listening to conversations among the pregnant women during waiting times, these indicated that testing is considered to be a requirement for a woman to deliver at the government hospital. The results of the test are recorded in a health book which the pregnant woman takes to the delivery ward, and it is believed among the women that maternity care is not granted by the midwives if the women do not show proof that an HIV test has been undertaken. Such claims were also made by one health professional who told the women during another talk that "a pregnant woman is required to have her blood tested, whether she wants it or not or they will be turned back during delivery" (HP7). Such observations suggest that some women may comply only at this stage in order to meet the requirements of receiving antenatal care at the hospital but drop out afterwards because they do not understand the need to continue with the treatment. This approach contradicts the ethos of client-centredness and

participation, and reduces the agency of the women to act independently based on their knowledge. In such circumstance, the "life-world" of the patients is ignored (Candlin, 2006; Monjok et al., 2010; Haith-Cooper and Bradshaw, 2013); for instance, the anxieties of the women and the challenges they face (social-cultural aspects) could be granted some attention in order to accommodate the emergent discourses other than solely delivering the official and medical knowledge (Higgins and Norton, 2010).

Apart from the reproduction of institutional structures, in the data there were also references to the wider social practices in which the institution is embedded. The health professionals as well as the women constructed the social practices that challenge the clients' agency in response to HIV prevention and care. The social practices in marriage, communities, and government institutions in Malawi reflect social inequalities, such as of gender, in economics, and education. Reflected in the talk are those social practices that give rise to inequalities affecting prevention and management of the HIV/AIDS pandemic in this study context. The next example, Example 6.2, demonstrates how the social and institutional structures influence the interaction of the participants at the clinic (e.g. Waitkzin, 1991; Wodak, 1997).

Example 6.2: Direct criticism

Context: The excerpt below is taken from a female health professional (HP1) talking to a group of 15 women who were seeking antenatal services. This excerpt is towards the end of the talk.

1	*HP1:*	*Nde pali azimayi ena mumati tikakuyezani magazi lero*
	HP1:	So there are some women that when we conduct the blood test on you
2		*mukapezeka ndikachilombo kukuuzani kuti pitani*
		when you are diagnosed with the virus, and we tell you to go and
3		*mukayambe mankhwala mumati "ndikaafunse kaye abambo".*
		receive the medication you say "let me go and ask my husband first".
4	*W1/2:*	*mmm↓: [he he]*
	W1/2:	mmh↓: [heh heh]
	W:	[he he] ((ena kuseka))
	W:	[heh heh] ((Some laughter))
5	*HP1:*	*Mukakafika kunyu:mba:: abambo akukuuzani kuti:*
	HP1:	When you get ho:me:: and the husband tells you:
6		*>"ine zimenezo pakhomo panga pano ayi"<*
		>"I do not want that in my house"<
7		*nde inuyo mumasiya mankhwala aja chii (.)*
		then you drop the medication thump (.)
8		*chimene mungadziwe ndi chonena kuti moyo umene*
		What you should know is that the life that
9		*mukupanga ndi wanu (.) siwaaba:mbo (.)*
		you are establishing is yours (.) not the husba:nd's (.)
10		*ndi wanu ndi mwana (.)*
		it is for you and your baby (.)
11		*inuyo mungasangalare mubereke <mwana oti ali ndi kachilombo::?>*
		Can you be pleased to bear <a child that has a virus::?>
12		(2) *Tili limodzi? (.) Alipo angasangalare?*
		(2) Are we together? (.) Is there anyone who can be pleased?
13	*W:*	Ayi
	W:	No.
14	*HP1:*	*Kubereka mwana oti ali ndi kachilombo*
	HP1:	Giving birth to a baby that has a virus

15		*chifukwa choti abambo anamukaniza kumwa mankhwala?*
		because the husband was stopping her from taking the medication?
16	*W:*	A*yi*
	W:	No.
17	*HP1:*	*Ngati zafika* stage *imeneyo (.)*
	HP1:	If it reaches that stage (.)
18		*yoti abambo akukukaniza kumwa mankhwala (.)*
		of the husband stopping you from taking the medication (.)
19		*pezani munthu wina wapadera (.) mukambirane nawo abambowo,*
		find a third person, an outsider (.) and discuss with the man,
20		*mwachifatse (.) ndi momveka bwino, eti?*
		calmly (.) and clearly, right?
21	*W:*	*Mmm*
	W:	Mmh

The health professional (HP1) concludes the talk in Example 6.2 by giving the women advice which is part of counselling sessions (Peräkylä and Silverman, 1991); she does so by criticising the women on the practice of relying on husbands to make medical decisions on their behalf – a practice that is said to have adverse effects on adherence of mother to child HIV/AIDS preventive treatment because some women do not return for medication after consulting their husbands (Haas et al., 2016; Keehn and Karfakis, 2014; Mbweza et al., 2008; Tenthani et al., 2014). This practice is further reinforced in that no men were present at the antenatal clinics, despite the Ministry of Health's promotion of male involvement in pregnant women's visits to antenatal clinics (Aarnio et al., 2009; Kululanga, 2011; Nyondo et al., 2013). HP1 criticises the women for not taking full responsibility for the treatment when they are diagnosed with the virus by employing humour, probably to mitigate her enactment of power (line 6 ff, see also Chimbwete-Phiri and Schnurr, 2017). She creates a scenario of what the women who are diagnosed with the virus will say and what they will do when they get home. To which some of the women react with laughter (line 4) while some chuckled. She continues with the criticism by ventriloquising a man's deep voice to enact what the husband would say in response to the wife's inquiry "I don't want that in my house" (line 6). HP1's criticism has been reinforced by the use of humour, e.g. by ventriloquising and use of exclamations, i.e. "thump!" (line 7) which could reduce the seriousness associated with criticism (Weisfeld, 1993; Chimbwete-Phiri and Schnurr, 2017), although there is minimum laughter from the women.

HP1's talk relates to the cultural gender roles of Malawi that position the woman as dependent on the man in decision making about her health (Bwirire et al., 2008; Hardon et al., 2012). By referring to the woman in her scenario as someone who has to go home "and ask my husband first" (line 3) before she receives medication, reflects the structure of power that affects the women. Although one or two women laugh and with some resistance to this statement as shown by 'mmm:↓' (line 4) which in Chichewa is a negative to show rejection of the statement, most of them just laugh without rejecting what HP1 is saying. This kind of power hierarchy, a consequential social inequality, is reflected in studies that have cited the power of husbands over women in decision making as one of the contributors to high women's drop-out rate in ART and PMTCT programmes (Bwirire et al., 2008; Hardon et al., 2012; Keehn and Karfakis, 2014).

The inequality created by the gender relations is further reflected as she advises them to consider their lives and that of the baby. She employs a statement of empowerment to the woman so that they think of themselves and the baby without facing the restraints of the husband (lines 8-12). She rationalises her point with a question "Can you be pleased to bear <a child that has a virus::?" (line 11 with a slower pace of talk on the "<child that has a virus::>" and lengthening of the 'virus' which may add to the affective aspect of this question). As she repeats the question and asks the women if they can be pleased if they fail to protect the baby from the virus "because the husband was stopping her from taking the medication?" the women give a strong audible feedback "no" to both of the questions (13 and 16). HP1 proceeds to give the women advice on the solution to this problem, that if they fail, they should find a third party to speak to the man "clearly and calmly".

In this extract HP1 adopts her position of power as a medical expert to advise, criticise and instruct the women, while the women are addressed as having a subordinate role in this discourse, i.e., as those lacking rationality and dependent "on the husband". The social structure defined here is that of the man at the top of the structural hierarchy and the woman in a subordinate position, which affects the woman's agency in this talk as well as in the associated practices. The woman is positioned as having a double challenge in her enactment of agency as she has to depend on her husband's decision and at the same time respond to the institutional requirement of undergoing the test and receiving subsequent treatment to protect the baby. This scenario reflects a

contradiction of social relations in this context: between the power of the medical institution, as an authority over what the women should do to manage or prevent HIV/AIDS, and the traditional patriarchal authority that demands women's deference to men (Evans and Ndirangu, 2009; Angotti et al., 2011; Flax et al., 2017).

The participants discursively construct the power of the health professional in this extract. As HP1 advises the women, they grant her affirming verbal responses, "no" (line 16) and some minimal responses "mmm" (line 21), which appear to construct the health professional as the expert, which in turn reinforces her power in the talk. Thus, by advising the women, she adopts the position of a knowledgeable expert whereby power is exerted by those who know on those who are less powerful (e.g. Foucault, 1972b). As she presents the women do not resist her criticism; there is a hint of seriousness in her tone as she transitions from humorous criticism to giving advice. Here she asks thought provoking questions but in a closed-ended format (lines 11-12 and 14-15) which does not grant the women a chance to give any opinions apart from short affirming responses (see Frankel, 1984). Thus, the subordinate position of the women both at the macro and micro level of the discourse is reinforced in this talk.

In another extract (Example 6.3) the women confirmed the double challenge that they face in the social structure by explicitly relating their experiences to the issue of condom use. A little earlier before this extract, HP3 asks the women if they are using condoms to protect themselves. Although this question may not be relevant to all of the women, some of them respond by articulating the challenges that generalise what some women face in this cultural context.

Example 6.3: A discussion among the women

Context: *A female health professional (HP3) talks to a group of 23 women. In this extract, they are talking about the use of condoms for couples who are infected with HIV.*

1	W2:	*... komabe choyambirira chomwe chimachitika ndi chakuti (.)*
	W2:	…But the first thing that happens is that (.)
2	HP3:	Mmm
	HP3:	Mmh
3	W2:	*Azibambowa, monga mmene mwanenera kale eti?*
	W2:	these men, as you have already said right?
4		°*Alibe* experience *yobwera kudzayezetsa*
		°They do not have the experience of coming here to get tested
5		*kuti amve uphungu wabwino°*
		and to receive proper counselling°
6		*Ndizotheka iwe mzimayi*
		It is possible that you the woman
7		*ukutenga zozitetezera zija eti?*
		are getting the protective tools right?
8		*Nde pali azimuna ena amatha kungovara (.) mongokuyerekeza*
		But there are some men who (.) pretend to put it on
9		*iweyo ukamakhala udziwona kuti anzanga atani? (.)*
		so that you should think that my partner has what? (.)
10		*avala eti? (.)*
		has put it on, right? (.)
11		*komano nthawi zina pogwira ntchito paja angathe*
		But during the work he may
12		*<u>kuyigwetsera</u> mwina pansi paja (.)*
		<u>drop it</u> on the floor (.)
13		*iwe opanda kudziwa kuti chachitika nchani*
		without you being aware of what has happened
14		*nde zachitika kale*
		and it has already happened
15		*iwe ukazindikira kuti ufunse iyeyo akuyankha <u>zake</u>*
		when you realise it and confront him <u>he gives</u> unconvincing answers

16		(.) *pali amuna ena amapanga ziti? (.)*
		(.) some men actually do what? (.)
17		*amatha kupanga zimenezozo =*
		they can do that =
18	HP3:	*= tatiyeni tione bwino bwino njira imeneyo*
	HP3:	=Let's take a thorough look at this issue
19	W:	*((kuseka)) he he he he*
	W:	((laughter)) heh heh heh heh
((9 lines omitted as HP3 asks the women what happens when they have sex and asks questions that challenge the women))		
20	W3:	*IYAYI iweyo utha kumuumiriza kuti apange zimenezozo*
	W3:	NO, but you can force him to use it
21		*Pamene mwini wake sakutani? asakufuna*
		yet the man does not what? does not want
22		*komano kuti iye akwaniritse kuti iweyo yachipatala igwire ntchito*
		But for him to do what the hospital requires of both of you…
23		*Kwa iyeyo ayenera <u>kuvala</u> koma zamoyo wake asakutani? (.)*
		he must <u>wear it</u> however, about his life this man does not what? (.)
24		*sakudziwa bwino bwino*
		he does not really know
25		*nde monga mwanena kale kuti azibambo ambiri amatha kunena kuti*
		so as you have already said that most men say to their wives
26		*'tiyeni kuchipatala tikayezetse' eti?*
		'let's go to the clinic to get tested' right?
27		*koma amakanika kuti atani? Abwere.*
		but fail to what? To come
28		*oro azimayi ambiri kunoko amabwera okha amene*
		even most women come here alone
29		*>azimayi oyembekezera eti?<*
		>pregnant women right? <
30		*abwera kudzayezetsa magazi (.) aapeza nako (.)*
		they get a blood test (.) they test positive (.)
31		*apite kukawauza abambo akunyumba kwawo*
		they go home to tell their husbands
32		*ena amati 'kumeneko sindita? =*

		some men say 'I am not going to what?' =
33	W4:	= *['SINDIPITAKO']*
	W4:	= ['I AM NOT GOING THERE']
34	W5:	= *['sindingapiteko']*
	W5:	= ['I cannot go there']
35	W3:	*nde ameneyo umutengere chishango (.)*
	W3:	so even if you collect condoms for such a man
36		*achivala molongosoka?*
		can he wear it properly?
		((most of the women talking indistinctly))
37	*HP3:*	*Inu mmati bwa? Ee inu*
	HP3:	What are you saying? Yes, you.
38	*W6:*	*chishangocho amatha kuchiboora panthawi yomwe akuvala*
	W6:	They puncture the *condom* as they put it on.
39	HP3:	*osati he he atayamba iyayi? Koma akuvala.*
	HP3:	Not hh hh when they have started, no? But when putting it on.
40	W6:	*Nanga sali yekha amene, walorera kuti akuvala*
	W6:	Since he puts it on when he is alone and he has accepted to use it
41		*iwe ukuti amuna ako* (∧∧∧)
		and you are convinced that your partner (∧∧∧)
42	HP3:	*iwe sumamuona akamavala?*
	HP3:	don't you see him as he puts it on?
43	W:	((laughter)) heh heh heh heh
44	W10:	((kuseka)) *he he Ngakhale atayifinya iwe ukuona*
	W10:	((laughs)) heh heh even if he squishes it while you are watching
45	W:	Heh heh heh
		((laughter and chattering))
((Some lines omitted where HP3 asks the women at what point the man wears the condom and some of the women say the man wears it while they watch and talk about the cunning nature of the men))		
46	HP3:	*Chabwino, chabwino zikatero (.) eti?*
	HP3:	Okay, okay in that case (.) right?
47		*Zikatero tingoti zikulakwika kuti tikulephera kuwauza*
		It is just unfortunate that we fail to tell him
48		*koma sizimayenera zikhale choncho eti?*

		but that is not how things are meant to be right?
49		*Chifukwa ikafika nthawi yovala kondomu ija*
		Because, when it comes to the time of wearing the condom
50		*imafunika kuvala akatota, eti?*
		is supposed to be worn when one is erect, right?
51	W:	*Eee*
	W:	Yes
52	HP3:	*Watota muja (.) nde iwe mzimayi utenga chani? (.) kondomu ija*
	HP3:	He is erect (.) and you the woman are to get the what? (.) the condom
53		*uyang'ana date yake kaye*
		you check the expiry date first

Example 6.3 illustrates active participation on the part of the women to the health professionals' advice of using condoms when one is infected with HIV in order to prevent any increase in viral load. This example is an expression, by the women, of their position in the social hierarchy, which influences their agency to apply the medical knowledge in actual practice. In Example 6.3, the women's agency is prevalent in the talk as they negotiate what the practice of condom use entails, through active resistance of the HP3's advice (lines 1-4 and 20-21). It is through such active resistance that clients here have initiated a negotiation of the practicalities of this preventive measure of using a condom (e.g. Stivers, 2006). This form of resistance is crucial in the construction of HIV/AIDS discourse, it illuminates the position of the 'less powerful' as existing power relations and ideologies are reflected in the talk (Flowerdew, 2008: 204).

The women's agency in practice is expressed where they refer to the woman who has the agency to collect the tools of HIV protection – a condom (e.g. lines 6-8) – but fails to make the man use it appropriately. The women's agency is demonstrated in the practice that is constructed in the statement as well as in the talk as they speak loudly and emphatically to negate what HP3 has said. The first woman (W2) refers to the contradictions they face of their own power 'the woman who confronts the man' (line 15) and their limitations, as they face the hurdle of a man who gives "unconvincing answers" (line 16). However, the woman also needs to meet the requirements of the clinic, as a regulative institution that instructs her what to do – as is openly stated by W3 ("…what the hospital requires of both of you" in line 22); yet there is the husband as a co-actor within the social structure in which she operates (van Leeuwen, 2008).

The women in Example 6.3 express how their husbands' failure to go the clinic and receive proper counselling affects their adherence to the recommendations, such as that of using a condom (lines 4-5 and 30-36). The subject discussed in this extract exhibits a strong correlation between declarative and procedural knowledge, which is concomitant with the relationship between medical and experiential knowledge. Thus, the women use their experiential knowledge as a resource to negotiate the medical knowledge (Boardman, 2014). The talk reflects the woman who knows what she has to do but fails to do so because of her subordinate position in the social hierarchy, thereby revealing a tension between the official medical knowledge and the experiential knowledge.

As some of the women express these challenges they reflect a tension between the discourse of the medical and social institution (Fairclough and Wodak, 2010), such as the institution of marriage within a patriarchal structure. The extract expresses three regulations: the use of condoms, the need for couples to have the HIV test together, and for pregnant women to be accompanied by spouses. In Example 6.3 the women express the actual experiences that they face regarding the 'hospital regulations' namely, a man who does not want to use a condom (lines 20-22); does not want to go for an HIV test (lines 32-34) and does not accompany his pregnant wife to the antenatal clinic (lines 28-29). By articulating such statements the women show their acceptance of the medical discourse as the authority but hint at the existing tension with regard to the social-cultural discourse. This leads to a negotiation of expert knowledge and experiential knowledge as the nurse asks questions to elicit effective practices in condom use while the women challenge the nurse and relate their comments by drawing from actual life experiences such as a man who "punctures a [condom] as he puts it on" (line 38) or some men who refuse to go to the clinic for a test, despite the wife's HIV positive serostatus (line 31). By relating these experiences the women portray how their agency and their role in the HIV/AIDS discourse is diminished by their low position in the social hierarchy of this patriarchal society.

In this extract, the women represent themselves as knowledge bearers, but they admit their limitations to act when dealing with their spouses. In the talk the women construct their 'helplessness' to act as informed and empowered individuals. In addition, by relating their experiences and referring to institutional requirements they appear to understand what has to be done and they enact their knowledge which is a sign of

empowerment at the level of interacting with the information (Finn and Sarangi, 2010; Schiavo, 2007) but not in actual practice. By raising these statements the women express their procedural knowledge which is in contradiction with the declarative knowledge of the medical institution. The actual differentials between practices learnt at the clinic and the realities of everyday sexual practices are constructed in this talk (van Dijk, 2001; Wodak, 1997).

It is observed that the women's level of engagement in negotiating knowledge in this talk by HP3 (from which Example 6.1 is taken) is higher than those of other sessions by the rest of the health professionals. The agency of the women in this talk is enacted as the women have relatively long talking turns (about 16 lines for W2, and 15 lines for W3) and frequent turns to actively explain what happens in actual practice. As HP3 asks encouraging questions, various women present their views, while a lot more laugh and some women collaborate with their fellow women to express the challenges, for example where W4 and W5 completed W3's statement "I am not going there"/"I cannot go there" (in lines 32-34). With this kind of interaction, this example demonstrates how HP3 appears to allow other emergent discourses which are important for effective discussions of HIV/AIDS prevention and management (Aulette-Root, 2010) but are mostly ignored in HIV/AIDS official discourse (Higgins and Norton, 2010). Nevertheless, in the end the health professional takes the control of the talk as evidenced by her interruption of the women's chatter with "okay, okay" (line 46) and her continuation of advice "that is not how things are meant to be…" (line 48 ff). In this case, the influence of the women's articulation of the challenges – to represent local discourses of HIV/AIDS – on the medical and official discourse is not clear, but it is observed that the talks usually focused on reiterating the advice, despite the difficulties in application as reflected by the women's talk (e.g. Watermeyer and Penn, 2012).

In the above examples there is articulation of the institutional context (social practices, social and institutional structures) that shape the HIV/AIDS talk; however, the influence of the micro aspects of the talk (e.g. the women's talk) on the institutional structures pertaining to HIV/AIDS is not apparent. What is apparent is that there is a tension between the institutional and domestic social structures. The effect of such social structures and associated hierarchies on the discourse of HIV/AIDS is also reflected in the asymmetrical relationship between the health professionals and the women as they interact in the healthcare contexts (Donahue et al., 2012). The next section examines instances where the healthcare professionals' discursive strategies generate ambiguous

functions, most of which reinforce the asymmetrical relationship that exists between them and the clients.

6.3 Power relations between clients and health professionals

This section discusses how power and control is reflected in the discourse to reinforce subject positions. Relationships among the participants are created as they engage in the talk, which is a form of social interaction (Norris, 2008). Participants can construct their position – "self-categorisation" or "other-categorisation" – through interactional techniques and this is either done explicitly or implicitly as they perform "category bound activities" (Gülich, 2003: 254), for instance when the health professionals ask questions and the women respond, or when the health professionals allocate time for the women to ask questions. As discussed in Chapters 4 and 5, the health professionals use collaborative strategies; for instance, by asking questions the health professionals are able to elicit information from the women and encourage participation. In other instances, similar strategies appear to reinforce asymmetries of power among them.

This section discusses how the health professionals' discursive strategies that sometimes work to actively engage the women were employed alongside other discursive strategies that perform contradictory functions, such as interruption, shifting topic, and sometimes silencing responses to the women's comments. These counter-strategies were mostly employed in reaction to clients' unelicited initiatives, such as questions and comments. These contradictory strategies in turn may categorise the participants in various relational positions in the social structure. The way health professionals position both themselves and the women, and how the women position themselves and the health professionals is analysed using several examples below.

Referring back to Example 6.3 in Section 6.2, the women and HP3 largely collaborate in their reproduction of knowledge, although the women have contradictory opinions to that of the health professional. As they negotiate and reproduce knowledge collaboratively – as was evident from the lengthy and frequent turns of the women and episodes of laughter – HP3 orients to her role as an information provider and advisor, while the women are relegated to their less active position. Despite the challenges raised by the women as they negotiate what HP3 says should be done during condom use and the difficulties that the women raise (of using the condom when the man is not

complying), eventually HP3 interrupts one of the women's explanations (turns 46-47) to describe how the condom should be used effectively.

HP3 proceeds to give the women information on condom usage, for example when and how the man should wear it. This information is clearly known by the women, based on the challenges they raise in this extract (Example 6.3) about the man who seems to puncture the condom during usage despite agreeing to use it. HP3 delivers this talk which may be challenging to the women as they are the only ones present and not the man with whom the activity is done. In this case, there is a contradiction in that the women's participation in what should be done to deal with the problem is not tackled, rather HP3 continues to explain how to use a condom, perhaps as required by the counselling guidelines (lines 48-53). HP3 moves from the mode of discussion that she had with the women and orients to information delivery (on how they should use a condom) and advising as typically used in HIV counselling (Silverman, 1997). She does this without negotiating with the women on a proper conclusion on how to deal with the challenge that is raised. By orienting to her role as information provider, HP3 regains her power over the women who also return to a less active listening position as they grant her shorter affirmative responses, such as "yes" (line 51) and were observed to give shorter responses during the rest of the topic.

In another extract, see Example 6.4, a female health professional (HP1) engages the women in asserting how they can prevent the baby from contracting HIV by asking them questions. She elicits information from the women and the women orient to the collaborative angle of the talk.

Example 6.4: Shifting topic of discussion

Context: A female health professional (HP1) talking to a group of 14 pregnant women. At this stage, they are talking about specific ways of preventing transmission of HIV from mother to child.

1	HP1:	*Mayi wapezeka kuti ali ndi kachilombo ka HIV (.)*
	HP1:	The mother is diagnosed with HIV (.)
2		*angamuteteze bwanji mwana wake (.)*
		how can she protect her child (.)
3		*kuti asatenge HIV*? (6)
		from contracting HIV? (6)
4	W1:	*Apite kuchipatala akayezetse magazi*
	W1:	She should go to the hospital for a blood test.
5	HP1:	*Choyambirira, apite ku chipatala akayezetse*
	HP1:	The first thing, she should go to the hospital to get tested
6		*adziwe kuti kodi ali ndi kachilombo (.) kapena alibe, eti?*
		to know whether she has the virus (.) <u>or not</u> right?
7	W((some)):	*mmm*
	W((some)):	mmh
8	HP1:	*Chachiwiri? (.) Ngati wapezeka nako kachilombo?*
	HP1:	The second thing? (.) if she is diagnosed with the virus?
9	W2:	*Alandire zotsatira ndi [mankhwala amene ampatse]*
	W2:	She should accept the results [and the medicine she receives]
10	W3:	*Alandire treatment*
	W3:	She should receive the treatment
11	HP1:	*Alandire treatment (.) ayambe kulandira ma ARV (.)*
	HP1:	She should get treatment (.) she should start receiving ARVs (.)
12		*Adzimwa <u>mwadongosolo,</u>*
		Taking the medicine according to the regulations,
13		*>mwamalamulo akuchipatala< eti?*
		>according to hospital regulations< right?
14	W:	*mmm*
	W:	mmh
((7 lines omitted during which they continue to list the ways of preventing HIV infections))		

15	HP1:	*Njira ina yotetezera kuti mayi*
	HP1:	Another way of preventing the mother
		asapatsire mwana kachilombo? (4)
		from transmitting the virus to the baby? (4)
16	W4:	*Adzikagona ndi abambo modziteteza*
	W4:	She should have protected sex with her husband.
17	HP1:	*Adzikagonana ndi abambo pogwiritsa ntchito kondomu?*
	HP1:	She should use a condom when having sex with the husband?
18		*Chabwino. Pogwiritsa ntchito kondomu*
		Alright. Perhaps it will be possible
19		*mwi:na zikhoza kutheka eti?*
		by using a condom, right?
20		*Komano nanga mimba ibwera- yabwera bwanji*
		But in that case, how can- has she conceived
21		*ngati akugwiritsa ntchito kondomu pamenepo, eti? =*
		if they have been using a condom? Right? =
22	W5:	*=koma mimba ndiya abambo omwewonso*
	W5:	=And the pregnancy is by the same man
23	HP1:	*mmm*
	HP1:	Mmh
24	W5:	*nzovutanso he he he*
	W5:	That is a difficult one heh heh heh =
25	HP1:	=*Chabwino, chabwino iyoyo ya kondomu mwina tiisiye uko*
	HP1:	Okay. Okay, perhaps we should put the condom issue aside
26		*tikambebe njira zina (.) Komabe ndizofunikira eti?*
		let us mention other ways (.) However it is important (.) right?
27		*chifukwa nthawi imene munali woyembekezera inuyo*
		Because at the time you are pregnant,
28		*ngati inuyo muli HIV negative, abambo ali HIV positive…*
		if you are HIV negative, and the man is HIV positive,
29		*kapena abambo simukudziwa zotsatira zawo*
		or you do not know your husband's test results
30		*chimakhala chapafupi kuti inuyo mutenge HIV*
		it is becomes easy for you to contract HIV
31		*ndipo mwana wanu mumampatsira mosavuta (….)*

		and you transmit it to your child very easily (….)
32		*Tili limodzi?*
		Are we together?
33	W:	*Mmm*
	W:	Mmh

In Example 6.4, HP1 asks questions on how to prevent HIV transmission from mother to child to which the women respond (lines 1-14). As discussed earlier (in Chapter 5) these questions facilitate knowledge sharing and collaboration among the participants. The questions also facilitate the direction of the discourse and establish what sort of knowledge to talk about as she presupposes shared knowledge with the women. As the women respond to the questions HP1 utilises the responses to present the legitimate discourse. HP1 presupposes that the women have basic knowledge (see section 5.3.1 in the previous chapter for a detailed discussion of presupposed knowledge) about HIV/AIDS and asks a string of questions. For instance, at the beginning of the extract HP1 asks the women how a mother who is HIV positive can transmit the virus to her child (lines 2 and 3) and one of the women responds by saying that she should go to the hospital to get tested (line 4). HP1 uses this response to instruct the women by rephrasing the women's answers. As HP1 repeats the women's responses (lines 4 and 11), as a way of reinforcing the official knowledge in the talk, by using repetition and additions she is implicitly instructing the women that 'this is what we should say'. Although the information is already known to the women (as seen from their answers), by eliciting the women's answers HP1 ratifies the women's statements and legitimises their articulation of the issues.

While the women present their answers, thereby participating in the reproduction of knowledge, the health professional appears to maintain her authority by controlling the selection of topic in the talk. As in classroom discourse, although the teacher may adopt an apparently constructivist approach to engage the students as knowers (Buzzelli and Johnston, 2001), HP1 is in authority as she grants the women an opportunity to speak about what they know about HIV. However, she controls the topic that they share at this point, and thereby remains in control of what is legitimate within this context by regulating other emergent discourses (van Leeuwen, 2008). For example there is a moment of interruption and lack of encouragement to the initiation of a question by one woman. In Example 6.4, as the women respond to her questions on the prevention of

HIV, one woman provides an answer that seems not to be in line with the expected answer (line 16) and is followed by comments that could potentially change the direction of the questions to address the challenges posed by the 'wrong' response. For example, one woman (W5) joins in resisting the incorrect response to challenge the notion that using protection for pregnant woman raises (lines 22 and 24). She opens her statement with "and the pregnancy is by the same man" as a rejoinder to HP1's statement (in line 21). The woman's (W5) utterance represents the discourse of the clients, i.e., to present the difficulties of interlinking declarative knowledge that is prevalent in the counselling talk with practical "procedural" knowledge.

By commenting, the woman orients to the collaborative nature of the talk and she enacts agency in the interaction. Through this initiative, to comment, the woman gains temporary control of the topic as she collaborates with HP1 in objecting to her fellow client's response. However, the knowledgeability enacted by the woman (in lines 22 and 24) is immediately dismissed by HP1. This is seen when HP1 responds to the woman's comment and laughter with an emphatic "okay, okay" (line 25) as a way of dismissing the subject. This is seen as a lack of encouragement to the comment which positions HP1 as the one in control of the topic and on how the discussion should proceed – especially when she says, "we should put the condom issue aside let us mention other ways" (lines 25-26). HP1 ignores the potential diversion of the subject that the woman's comment (in lines 22 and 25) had, which could potentially lead to inclusion of the issues of condom use and to discuss the challenges that one of the women referred to. By avoiding the diversion of topic, HP1 positions herself as the expert controlling what the women discuss and raise in this forum. This is also asserted by Waitzkin (1991: 40) that "in what is left unsaid, interrupted, cut-off or de-emphasized" there is a reproduction of the institutional context and this is reflected in this discourse. This way HP1 ignores the actual experiences that the women, who may have the procedural knowledge about HIV/AIDS and as "expert patients", may share (e.g. Sanderson and Angouri, 2013).

HP1, however, uses her authority subtly (in lines 29 ff) when she does not explicitly reject the woman's answer but uses a question and the lexis " 'perhaps' we should put the condom issue aside" (line 25) to hedge her rejection. This is the paradox of the health professional's role: to be in control of the selection of the topic but at the same time not to deny the women's agency in the talk (see also Buzzelli and Johnston, 2001). Consequently, HP1 acts as a gatekeeper on the topics and how they are to be discussed

(Vickers et al., 2012). Thus in the last instance control over selection of knowledge is held by the health professional as she guides what should be mentioned in this talk. HP1 illustrates what constitutes legitimate knowledge in this interaction by focusing on declarative knowledge rather than going into practical details of condom use and its challenges.

HP1, in Example 6.4, also demonstrates her position as an expert when she evaluates the responses of the women as they respond to her questions. In this talk HP1 asserts a degree of certainty as to what knowledge is correct and what is not. By repeating the women's answers and adding to the responses (lines 5 and 10) she ratifies the correctness of the responses. Where she is not in agreement with a client's answer (e.g. lines 17 to 21) she repeats the client's response in the form of a question, explicitly expresses her doubts and asks a further question in order to correct the idea. In this case, HP1 exercises her epistemic stance as a teacher and expert by selecting what is said and guiding how it is said by the women, which could potentially frustrate the women's views.

Example 6.5 is an example of a certain degree of resistance given by the health professional to one woman's enactment of agency in the talk. This extract is from the same session as that of Example 6.3 quoted in section 6.2 above.

Example 6.5: Woman's testimony

Context: The female nurse (HP3) and 23 pregnant women; this is a session from the same talk as Example 6.3. This is towards the end of the session when she invites questions. Earlier on they have been talking about the importance of HIV testing even before choosing contraceptive methods. HP3 had just mentioned that the Norplant method is not effective for women taking ARVs.

1	HP3:	*Mafunso alipo?*
		any questions?
2	W1:	*Kumbali ya norplantyo nde mafunso palibepo (.)*
		No questions on the issue of Norplant (.)
3		*Komano izozo ndi zoona ndithu*
		But it is really true (.)
4	HP3:	*Zikumachitika?*
		It's happening?

5	W1:	*Eee siyovomerezeka* (.)
		Yes, it is not a recommended one (.)
6		*ena akumatenga mimba ali ndi norplant pati?*
		some are conceiving while having Norplant inserted where? (.)
7		*pankono*
		on the arm (.)
8	HP3:	*Eti?*
		Right?
9	W2:	*Ee siyovomerezeka (2)*
		Yes it is not an accepted one (2)
10	HP3:	*Mafunso? (6) Palibe? (.) Zamveka?*
		Questions? (6) None? (.) Well understood?
11	W:	((ena)) *Eee zamveka*
		((few)) Yes, it is understood.

In Example 6.5, HP3 draws her talk to a close, and opens time for questions according to a common practice in the counselling sessions. Instead of asking a question, one woman (lines 2 and 3) collaborates with HP3 by sharing a testimony of the challenges of using Norplant as a contraceptive for women who are diagnosed as HIV positive. By sharing the statement, the woman positions herself as an expert with a social voice in evaluating the information given by the health professional (Fisher, 1991). With such engagements, such as telling a story as done here, the client exercises her authority in the encounter (Clark and Mishler, 1992). By doing this W1 temporarily exercises her power to explain, drawing from her experience and local knowledge to agree with the nurse and reinforce the knowledge to her fellow clients. Her commenting appears to be a response to the mode of permitting lengthy discussions that HP3 employed earlier on before this extract (such as in Example 6.3), and presents a potential for the women to level out the asymmetrical power relations between themselves and the health professional.

Although the woman's comment is responded to by HP3 (lines 4 and 8) she does so minimally except for questions that are aimed at getting the woman's confirmation, "it's happening?" (line 4) and "right? (line 8). In the end she does not acknowledge the woman for making the comment. Instead, HP3 appears to aim at questions from the women because she resumes talking by continuing to ask the women if they have any

questions (line 10). This might create an awkward moment for the woman where there is no clear acknowledgement to the comment she made, but by repeating invitations for questions (line 10) HP3 signals the importance of the questions over the comments. Yet by commenting and citing the testimony the woman signifies a strong engagement in the interaction by sharing (declarative) knowledge which is explicitly called for by the health professionals in the talk (e.g. section 4.4.1). This is similar to what Sanderson and Angouri (2013) found, that sometimes there is resistance from medical practitioners when patients initiate displays of knowledge based on their experiences – experiential knowledge.

The health professionals enacting their position as knowledgeable and expert sometimes leads to resistance to some of the clients' unelicited contributions, as previously seen in Example 6.5, a comment was resisted where questions were expected. Another extract (Example 6.6) illustrates how despite a strong engagement of the women in the talk one client's assertion of knowledge, by asking a question, does not seem encouraged.

Example 6.6 : Clients' questions

Context: Female counsellor (HP1) talking to 14 women during an antenatal talk. At this point she explains how breast feeding can be done when a mother with HIV has a sore breast.

1	HP1:	*Inuyo mwapezeka ndi zilonda za mmawere kapena mwana wanu*
	HP1:	You have breast sores, or your baby has sores in the mouth,
2		*ali ndi zilonda za mkamwa, inuyo muli ndi kachilombo, mutani*
		and you have the virus, what should you do
3		*kuti mumuteteze mwana wanu? (2) Mungapange chani?*
		to protect your baby? What can you do?
4	W1:	*Kuthamangira ku chipatala*
	W1:	Rushing to the hospital.
5	HP1:	*Muthamangira ku chipatala?*
	HP1:	You will rush to the hospital?
6	W1:	*Mmm, kuti aka[tithandize]*
	W1:	Mmh, to be as[sisted].
7	HP1:	*[Zikomo] kwambiri. Kuti akakuthandizeni Zikomo kwambiri*
	HP1:	[Thank you] very much. To be assisted. Thank you very much.

8		*Ena mungapange bwanji? (5*)
		Anybody else? What can you do? (5)
9		*Pali njira zambiri zomwe mungathe kuchita (.) Timanenanso kuti*
		There are many ways that you can follow (.) We also say that you
10		*Mudzikatha kufinya mkaka (.) kufinyira mkapu eti?*
		should squeeze the breast milk (.) squeezing into a cup, right?
((several lines omitted during which she explains what ought to be done to keep the milk safe))		
11	W12:	*Tsono popeza zimatha kutheka bele kuturuka chotupa mkatimu (.)*
	W12:	But it is also possible that the breast can have a swelling inside (.)
12		*choti sichinayambe kutuluka bwinobwino (.)*
		that is not yet showing on the outside (.)
13		*koma kumangotupa*
		but it is just swollen (.)
14		*nde bele limenero mwana angayamwe*?
		can a baby suckle that breast? =
15	HP1:	*=Ndi zimene ndikunena ku::ti*
	HP1:	That is what I am saying tha::t(.)
16		*mwana asayamwe*
		the baby should not suckle that one (.)
17		*koma mudzingofinyira mkaka mu chani? Mukapu (2)*
		but you should just squeeze the milk into a what? A cup (2)
18		*cholinga chophitsa mkaka uja ndichonena kuti*
		The reason for warming the milk is that
19		*Kachilombo ka HIV ngati kangeramo mu kapu katani? (.) kafe*
		if HIV is in the cup it should what? (.) It should die.
20	W12:	*Mmm*
	W12:	mmmh

In the excerpt, Example 6.6, HP1 is in the middle of her talk and a woman asks her a clarifying question (lines 11 to 14). HP1 seems less prepared for the woman's question. Prior to this excerpt she seems pleased to have the women's responses and acknowledges the responses with a "thank you" (e.g. line 7). At the beginning of this talk and in another separate talk, she said "thank you" several times on different occasions to acknowledge the women's answers to her questions. HP1's response to the

women's feedback changes when the client asks the question. By her tone of response, she seems less interested. The opening of HP1's response to the woman's question, "that is why I am saying tha::t…" (line 15) with lengthening of the word "that" could be construed negatively by the questioner.

By responding in this way, HP1 reinstates her own status as expert and the more knowledgeable person. It sounds rather condescending as she does not sound pleased to respond to the question which indicates that the woman should have listened better. Her tone of response sounds limiting to the kind of interaction that is anticipated in this context – 'discussing' – while she takes charge of the ongoing talk. Although she responds to the question she does not attempt to acknowledge it as she did when the women gave correct answers to her questions earlier in the talk. It could be because the question is not invited at this time and the health professional is not prepared for it. This positions the women as passive listeners and respondents to HP1's questions. It is as if the women are required to ask questions only upon being requested, hence reinforcing the institutional relationship (Waitzkin, 1991), in this case of expert and non-expert. Example 6.7 illustrates how another health professional reacted to a client's hint of disagreement, which also reinforced the power asymmetries between them.

Example 6.7: Correcting information

Context: A male counsellor (HP4) is talking to a group of 16 pregnant women attending antenatal clinic. At this stage they are talking about sexually transmitted diseases.

1	HP4	*Mungatiuzeko matenda ena opatsirana,*
	HP4:	Can you tell us other sexually transmitted diseases,
2		*kupaturapo HIV, Edzi? Matenda ena?*
		apart from HIV/AIDS? Other diseases?
3	W1:	*Chizonono*
	W1:	Gonorrhea
4	HP4:	*Chizonono, eti?*
	HP4:	Gonorrhea right?
5	W2:	*Chi[ndoko]*
	W2:	Sy[philis]
6	W3:	*[chindoko]*
	W3:	[Syphilis]

7	HP4:	*China? (.) Mabomu?*
	HP4:	Any other? Genital warts?
8	W:	*Eee*
	W:	Yes
9	HP4:	*Eee (.) china chani? Mawuka?*
	HP4:	Yes (.) any other? Bacterial vaginosis?
10	W4:	*Mawuka samapatsirana*
	W4:	Bacterial vaginosis is not sexually transmitted
11	HP4:	*Eee::* >*zopatsirana basi (.) zokandakanda basi*<
	HP4:	Yes, >sexually transmitted they are (.) all those causing itchiness<
12		*Zokandakanda zimenezo::zo ndi zopatsirana pogonana eti?*
		Tho::se causing itchiness they are sexually transmitted right?
13	W:	mmm
	W:	Mmh
14	HP4:	*Yes zizindikiro za matenda amenewa ndi zoti,*
	HP4:	Yes, symptoms of these diseases are that
15		*kumaliseche kwa munthu amene ali ndi matenda amenewa, eti?*
		The genital area of the infected person, right?
16	W:	((ena)) *Mmm*
	W:	((few)) Mmh
17	HP4:	*kumakhala zilonda*.
	HP4:	has sores

Example 6.7 demonstrates how in the midst of quick questions and answers one woman (line 10) changes the formulation of the women's responses, which is mainly about affirming HP4's talk with "mmm" or "yes" as mostly done. The woman expresses scepticism at the notion that *mawuka* (bacterial vaginosis) is a sexually transmitted disease (line 10) a point that is raised by HP4 (line 9). Her objection demonstrates that some of the women's responses to the talk are not just mechanical affirmations of HP4's statements but that they are fully engaged in the negotiation of knowledge and can be selective about what they obtain. HP4 quickly responds to the woman's challenging utterance in the form of an objection "yes, …they are" and confirms it with the rest of the women that all those diseases listed are sexually transmitted (line 12). In so doing, he enacts his expertise as the bearer of knowledge, especially when he does not seek clarification from the woman (W6) but continues to deliver a brief explanation.

This could be a missed opportunity for a discussion when he does not directly ask the woman who objected to check her satisfaction with the given explanation; instead he proceeds to provide more information about the sexually transmitted diseases (line 14 ff). He proceeds with his style of ensuring that the women confirm what is presented (lines 12 and 15). By not directly addressing the woman's objection he leaves the potentially critical issue (believing that bacterial vaginosis is not sexually transmitted) undealt with.

In trying to understand why this woman may have raised this point about bacterial vaginosis, which is locally known as *mawuka,* and is a common disease among women*,* I consulted a Malawian medical doctor on the English translation of the condition referred to above (lines 11, 12). In his conversation the doctor stated that this is translated "bacterial vaginosis" and that this condition is common in women and comes in various forms related to vaginal itchiness or discomfort but with different causes, i.e. fungus, bacterial or hypersensitive reactions, but generally referred to by one term by most women. Thus it seems that the woman raises a valid point, which may be held by many more women and therefore needs clarification by HP4; instead the woman is silenced when HP4 quickly dismisses the woman's doubt (line 11). This extract (Example 6.7) is another instance of the women having agency in the talk to negotiate knowledge with the health professionals. However, being dismissed as was done in this example means that to an extent, the clients' talk does not have a significant influence to change the discourse at the social and institutional level, for example there are limitations for the women to influence diversions or changes of topics, or prolonging of the time spent on a particular topic of discussion. This, in turn, reflects the diminished influence that the women's local knowledge has to the HIV/AIDS discourse within the medical institution (e.g. Drescher, 2010).

In another instance (Example 6.8), HP4, quoted in the previous example (6.7) relates how an HIV test is performed while the women give responses to indicate that their capacity to understand the information was challenged. The women's resisting responses however, do not deter HP4 from delivering more information.

Example 6.8: Client's feedback on technical information

Context: HP4 talks to 15 pregnant women during antenatal visits. At this point he has finished giving basic information about HIV/AIDS and is explaining the HIV test procedure to the women

1	HP4:	*Apa ndiye timatenga chipangizo china (.) chachiwiri*
	HP4:	So at this point we get another kit (.) a second one
2	W:	*Mmm*
	W:	Mmh
3	HP4:	*Chimene chili (.) <u>ichi</u> (.) chimenechocho timatenganso magazi*
	HP4:	That is (.) this <u>one</u> (.) we use this and take another blood sample.
4	W1:	*iiii sitikusiya[nitsatu ife]*
	W1:	eish we can't tell the [difference]
5	W2:	[*nde (tikumbukira?)]*
	W2:	[so will (we remember?)]
6	W:	((indistinct speech))
7	HP4:	*<u>Eee</u> iii basi bola mudzingomva* ((in a playful voice))
	HP4:	*<u>Yes</u>, that's it, as long as you hear it* ((in a playful voice))
8	W:	*Mmm*
	W:	Mmh
9	HP4:	*Nde chimenecho titenga magazi ndikuyika apa (.) pamenepa.*
	HP4:	So with that we take a blood sample and place here (.) right here
10		*Chimenechonso chikangolemba mizere iwiri*
		When that also indicates two lines
11		*kusonyeza kuti tsopano uyu ndi ine tapulumuka*
		it means this one and I are vindicated
12		*chifukwa choti umboni tatani? tapeza eti?*
		because we have got what? the evidence right?
13	W:	*Eee*
	W:	Yes
14	HP4:	*Kusonyeza kuti tikuuzani zotsatira zoona (.) sinchoncho?*
	HP4:	It shows that we will tell you the true results (.) doesn't it?
15	W:	*Mmm*
	W:	Mmh

		((Omitted 16 lines as HP4 continues to explain how the procedure is conducted)
17		((one of the women yawns audibly))
18		*nkumadikira (.) kwa nthawi yake (.)*
		and we wait for the results (.) the duration (.)
19		*chinacho ten minutes (.) koma isapitirire 45 minutes,*
		for this one ten minutes (.) but not exceeding 45 minutes
20		*chinacho 15 minutes koma isapitilire chani, 60 minutes eti?*
		the other for 15 minutes but not exceeding what? (.) 60 minutes, right?
21	*W:*	*Mmm*
	W:	Mmh

In Example 6.8, the health professional (HP4), as a provider of information, seems to orient to the institutional requirement of presenting as much information as possible to the women (see Section 4.3.1, Table 4.3 on variabilities of the health professionals' choice of topics). The extract occurs towards the end of the talk during which HP4 presents details of the testing procedure, including details of the kit that is utilised in the process. As he explains the details of the procedure, the information is construed as too technical for the women, this is evidenced by some of the women's verbal resistance that follow from his talk : "eish we can't tell the difference" and "so will we remember?" (lines 4 and 5) including some murmurs from the group (line 6). These women's reactions clearly indicate that the explanation is difficult to follow and too detailed to recall.

Despite HP4's effort to use a story (omitted here) and personification (e.g. line 11) to simplify the technical details in the explanation before this extract (not shown here), the details tend to be too much for the women as the women voice their confusion (lines 4-6). However, HP4 is not prepared to address their concerns as he downplays the women's reactions (line 7) and proceeds to explain the procedure with much more detail (line 9 ff). By reacting in this way he seemed unprepared for contrasting feedback that may have necessitated a change of pace in his talk. In this example HP4 portrays himself as the provider of information and an expert, whereas the women are constructed as passive learners, albeit playfully, as he says "that's it, as long as you hear it" (line 7).

The pacing of HP4's talk may be influenced by the institutional requirement of giving as much information as possible and is sometimes met with time constraints (also Angotti, 2010; Evans and Ndirangu, 2009). In Example 6.8, HP4 seems to grapple with the requirements of the HIV Counselling Protocol, which require him to go through all the stages of the talk and explain the details of the procedure to the clients within a given time (approximately 30 minutes). So as he approaches the end, he does not clarify the information missed by the women but continues to talk while the women proceed to give him affirming feedback although minimal – "mmm" (lines 15 and 21). The authenticity of the women's affirming responses to HP4's continued talk is not clear at this point but the symbolic nature of the verbal realisation of their assent appears indicative in terms of the institutional power asymmetries at work here. Thus, as he continues with this strategy of proceeding to give the talk while disregarding the women, he constructs himself as the one in authority, who has to be listened to regardless of the technical nature of the information. The nature of information which is portrayed as unclear to the women may also function to elevate his position as an expert and relegate the women as lay people.

HP4's talk in Example 6.8 was further constrained by some environmental factors, such as high temperature (thermometer on the wall indicated 32°C), a relatively small room filled beyond required capacity, and consequentially exhausted pregnant women who had already attended several stages of other procedures of their antenatal appointment before this talk (researcher's observation, see Appendix 10). In spite of this, HP4 managed to present almost all the topics outlined in the counselling guidelines while granting a minimal response to the women's indication of discomfort which they indicated by verbal and non-verbal feedback (such as several women fanning themselves and one took off her blouse to remain with just a vest). The set-up observed here, whereby HP4 presents as much as they could while disregarding the women's feedback, reflects the health professionals' way of fulfilling what the HIV protocol stipulates as an ethical and institutional requirement. Thus, reflecting the need to give people a chance to have the medical knowledge, make informed decisions, and granting them a responsibility over their health (Osborne, 1997) by giving them a lot of information. In this case however, the observed reaction of the women, by speech and by action (e.g. yawning in line 17, Example 6.8, and fanning themselves in reaction to the rising temperatures) indicates that they may have been too exhausted to be interested in this information at this point. But as 'learners' they had to sit and listen to the end.

The environment analysed in Example 6.8, reinforces the asymmetries of power between, on the one hand the medical institution (with all the regulations that the women have to follow) and the health professionals as the institutional agents, and the women on the other. Hence the medical interaction reproduces the institutional structure in which the medical institution is constructed as the dominant one with control over the clients (Fisher, 1991; Waitzkin, 1991), while the autonomy of the women to influence the nature of the interaction and the talk is almost minimal.

6.4 Conclusion

This chapter has focused on institutional and social structures embedding, and reproduced by the counselling sessions and asymmetries of power in the relationships between the participants. The discourse of counselling also relays the social practices and structures that embed the HIV/AIDS discourse in this setting (Sarangi and Roberts, 1999; Wodak, 1997). By using several examples it has shown evidence of social structures and asymmetrical power relationships reflected by the participants and facilitated by the institutional structures. Some of the health professionals, being aware of the context in which the women are situated, appear to reflect the women's low status in the talk by seeming to silence them (Examples 6.4, 6.8), not addressing pertinent issues the women raise (Example 6.3), sometimes not paying proper attention to unelicited comments and questions (Examples 6.5, 6.6), and undermining some of the women's feedback (Examples 6.7, 6.8).

The examples have shown that as the participants negotiate knowledge, the negotiation does not take place on an equal footing, and in most cases the healthcare provider takes a more powerful stance. In all the cases, power predominantly lies in the hands of the health professionals; however, depending on the health professionals some women are able to exercise agency temporarily over what is discussed. For instance, by raising the social challenges that they face as they attempt to comply with hospital regulations, by challenging the health provider when they do not understand or when they disagree, they enact a role of expert and gain authority in the talk.

The women are granted power through discursive strategies that enable them to share knowledge but in controlled ways which reinforce sequentially the powerful stance of

the health professionals. In addition, as the participants negotiate HIV/AIDS knowledge in some instances there is a form of resistance by the clients to the relaying of medical declarative knowledge, which illustrates that the health professionals and the clients may reproduce knowledge but it is of different kinds. There is experiential knowledge as the women relate their experiences, and orient to procedural knowledge, while most of the health professionals continue to steer the talk in concomitance with their role as information providers. Consequently, there is a negotiation of medical expert knowledge when, on the one hand, the health professionals as agents of the institution have presuppositions that the women know and will apply the acquired medical knowledge. On the other hand, the women who have challenges in actual practice, due to the existing social structures, remain in a disadvantaged position on the receiving end of information delivery, while their contributions are steered towards the legitimate medical knowledge and relevant local knowledge is ignored (e.g. van Leeuwen, 2008).

Hence, the women's ownership of local and experiential knowledge, which the health professionals may find useful in granting meaningful talk, is minimally accommodated in the talk. Therefore, the medical institution is seen to uphold the reproduction of declarative or medical knowledge while the women's agency in negotiating the place of local and experiential knowledge remains sidelined in this discourse. This imbalance in information shared at the clinic reflects the gaps in counselling formats whereby some of the women may be selective in what they obtain at the clinic, i.e. getting the test and ART treatment in order to fulfil the requirements of receiving antenatal services while experiencing challenges to comply with the recommendations when in their homes. Nevertheless, if the women's views were granted a place, the counselling sessions may have the potential to become a forum for meaningful and effective discussions.

The next chapter, Chapter 7, synthesises the findings presented in the analysis chapters (Chapters 4, 5, and 6) in order to explicate the sequential theoretical implications for studies in applied linguistics, while the implications of the findings for practice are raised later in Chapter 8.

Chapter 7: Discussion

7.1 Introduction

This chapter will discuss the findings of this study, setting out what it entails considering the larger body of knowledge to which it intends to contribute. It will first of all reiterate the research questions followed by a section on the summary of findings based on the analysis of the data undertaken in the previous chapters.

The study has mainly deployed an interactional sociolinguistics approach, with the support of selective CDA and ethnographic approaches, in order to examine the reproduction and negotiation of knowledge about HIV/AIDS by health professionals and clients during healthcare interaction in Malawi. This was conducted with the background that there is limited patient adherence to HIV/AIDS treatment, particularly, the HIV prevention from mother to child transmission (PMTCT) programme. As one way of addressing the challenges of treatment compliance, this study has utilised data from actual interaction during HIV consultations to investigate patients' participation in the discourse of HIV/AIDS at the health centre. Interactional data were supplemented by interviews with clients and health professionals, and observations of interaction and activities around HIV/AIDS care in the hospital.

The main aim of this study was to investigate the discursive practices of clients and health professionals in the reproduction and negotiation of knowledge about HIV/AIDS in the healthcare context in Malawi. Specifically, this was done to highlight how focusing on language and communication can help improve the current situation – of inadequacies in patients' compliance with HIV/AIDS treatment – in Malawi and where applicable in sub-Saharan Africa and beyond. The study's concerns were articulated in the following research questions:

1. How do participants reproduce and negotiate knowledge about HIV/AIDS in the healthcare context in Malawi?
2. What is the relationship between social and institutional structures and participants' agency in the reproduction and negotiation of knowledge in the healthcare context in Malawi?

The study has argued that examining the discourse of all participants in these HIV/AIDS consultations using applied linguistic methods leads to a clearer understanding of different systems of knowledge that have a bearing on outcomes of treatment utilisation and preventive practices.

The central contributions of this study touch on four elements as follows. The first is that the principal findings contribute to the understanding of nature of interaction between patients and medical professionals in a context where HIV/AIDS has competing discourses, which are therefore in need of improved healthcare communication practices. The results of this study provide interesting insights on the activities of counselling and healthcare interventions in general. The second is that, based on the variations of the interactions revealed in the analysis, it provides insights to the designing of more targeted interventions to improve the practice of counselling and health education. The third contribution touches on the methodology: the study contributes to studies in applied linguistics and medical discourse in general by demonstrating the practicalities of utilising applied linguistic approaches in the study of professional discourse, particularly, in the under researched context of Malawi and sub-Saharan Africa. The last contribution is that it presents theoretical insights: The study explicates the activities of reproduction and negotiation of HIV/AIDS knowledge within the framework of applied linguistics, thus contributing to their conceptualization in applied linguistics.

These insights from the study are discussed in this chapter, except for implications of the study for the practice of HIV/AIDS counselling, which are specifically outlined in Chapter 8.

7.2 Overview of findings and theoretical implications

The first research question (1) "How do participants reproduce and negotiate knowledge about HIV/AIDS in the healthcare context in Malawi?" has been addressed by elucidating that the contributions of the clients to the discourse were recognised, for instance when they actively reproduced their knowledge and negotiated knowledge of various types relating to HIV/AIDS with the health professionals. Examining the discursive practices of both the health professionals and their clients has shown that the reproduction of existing knowledge about HIV/AIDS in this context was a collaboration

between health professionals and clients, as each of them made a contribution to the discourse, despite differentials in knowledge sources, knowledge types and power. The different chapters have given a different emphasis to this first question. Chapter 4 established that the participants are collaboratively involved in the reproduction of knowledge about HIV/AIDS, while Chapter 5 has demonstrated that the health professionals used various discourse strategies to encourage the women to participate, such as forms of question and answer, local knowledge resources, stories and analogies to simplify technical ideas, and humour.

The analysis has shown that reproduction of existing forms of HIV/AIDS knowledge – obtained from community meetings and gatherings, media promotions, social networks and education talks at the health centre – was the dominant activity in the counselling sessions. On the other hand, in Chapter 5, it has been observed that there was negotiation of knowledge going on among the participants but this was to a varying degree, in that it was not only the health professionals who led the talk, the women played a role as well. There was a fluctuating degree of negotiation due to the tensions between local knowledge and medical knowledge, or common medical knowledge and technical medical knowledge, making the women more agentive to resist by laughing, commenting, asking questions, and interrupting with comments or questions (e.g. Examples 5.2, 5.5, 5.6). The variability in negotiation strategies also links to the variations in the health professionals' style of communication where some permitted collaboration in which the women enacted more agency (HP3 in Example 5.3) than others who appeared to restrict the agency of the women by following more structured sessions (e.g. HP1 and HP4).

Although the institutional structures are reflected in the discourse, the interaction was more collaborative than one-way communication. The health professionals and the clients negotiated the different sets of knowledge in ways that, on the surface of the talk, appear to exhibit collaboration. However, the micro analysis of the talk enabled me to see the subtleties in gradations of the negotiation – that they are not absolute, but more a matter of degree. The interactional sociolinguistic analytical methods enabled me to see the subtle shortcomings of the sessions with variabilities across the health professionals to reveal areas to which improvements in healthcare practice can be directed. In the end I do not necessarily recommend improvements that are standard across the health professionals, but make suggestions that are specifically aimed at specific gradations that are revealed in the data.

The second research question (2) “What is the relationship between social and institutional structures and participants’ agency in the reproduction and negotiation of knowledge in the healthcare context in Malawi?” has linked the idea of reproduction and negotiation of knowledge to the agency of the participants. In Chapter 6, the study has discussed contradictions in discourse strategies demonstrated by the health professionals as the macro level analysis of the talk exhibits complexities of power and social structures. It has revealed that there are ambiguities in the discourse strategies that some of the health professionals utilised, for instance: on the one hand client centredness was attempted and participation was encouraged; on the other hand, when the women responded to comments and raised issues that were not in line with the expected medical action, they seemed to be interrupted and silenced by the health professionals (e.g. Examples 6.2, 6.3, 6.4 and 6.5). This has suggested that most of the sessions preferred a reproduction of medical knowledge than a negotiation, such that the women’s comments and participation that were resisting the medical knowledge were prevented. Consequently, the negotiation of knowledge in the interaction was carried out selectively, with resistance by some health professionals to certain forms of knowledge emanating from the women.

Thus, it has been observed in this study that there was the potential for the agency of the participants in the discourse of HIV/AIDS but this agency was more prevalent at the micro level of interaction, while at the macro level, institutional and social structures mostly constrained the agency of the participants. Consequently, the findings have suggested that the *status quo* of social and institutional structures reflected in the discourse seem to operate largely independently of the interventions of the clients at the micro level of interaction or rather, the extent of the clients’ impact to change the institutional structures was oblique in the data. What was observable was that as some of the health professionals encouraged the reproduction of knowledge they appeared to reinforce the institutional structures and resisted the women’s agency in the talk (Examples 6.3, 6.4 and 6.5). Additionally, the responses to the social structures were underdeveloped in the participants’ articulation of social problems (Examples 6.3 and 6.4).

Thus the data that have been analysed in this thesis have revealed the full complexity of the processes of reproduction of knowledge, and how these are at times interactively negotiated among the participants. In this way, the participants in the context of

HIV/AIDS counselling sessions oriented to the power structures of the macro level of the discourse of HIV/AIDS in antenatal clinics but at the same time negotiated them and consciously challenged them at the micro level of the discourse.

The following sections will discuss the major findings of this study by focusing on emerging key concepts in order to lay out the implications of the study to the activities of HIV/AIDS consultations in Malawi and to applied linguistics in general. The sections are divided according to several related concepts as follows: knowledge reproduction and negotiation, strategies of collaboration, participants' agency, social and institutional structures, and the chapter concludes with a focus on the theoretical implications of the findings.

7.3 Reproduction and negotiation of knowledge

This study has focused on the interaction that takes place between the participants to understand their discursive practices in HIV/AIDS consultations. This section extrapolates the first specific question below:

> How do participants reproduce and negotiate knowledge about HIV/AIDS in the healthcare context in Malawi?

This question is mainly addressed in the analysis in Chapters 4 and 5, which has demonstrated that in this Malawian context the group counselling talk is a reproduction of knowledge rather than a construction of new knowledge. It is stated that in medical interaction participants draw knowledge from other sites and reproduce it in the immediate context of the clinic or classroom (Bernstein, 1996); for instance, doctors utilising knowledge from research and medical text books in the clinic as a site of knowledge reproduction (see also MacDonald, 2002) while all participants draw from other discourses to reproduce their knowledge and beliefs in interaction (Fairclough and Wodak, 2010). One of the notable concepts in the data, as the participants reproduced and negotiated knowledge, is the strategy of collaboration and this is explained in detail in section 7.3.1.

7.3.1 Collaboration in the reproduction of knowledge

Reproduction of knowledge is the main activity that is carried out in the counselling sessions, with several discourse strategies being manifested by the participants in the talk. It should be stated here that the sessions analysed in this study demonstrated some variations in how the discourse strategies were utilised and there are some variations in the participation of the clients. All health professionals used question and answer forms rather than delivering information unilaterally. However, there were variations in the discourse strategies across the health professionals. For instance, the question and answer forms were more distinctively creative in the case of one health professional (HP3) who included a more evaluative type of question which led to a more active participation from the women when they raised issues that touched more on cultural and local knowledge. Other health professionals (HP1 and HP4) utilised more direct, open-ended questions, which made the women more responsive in reproducing medical knowledge. Yet another used some closed-ended questions besides the open-ended questions (HP4) that, in some cases, resulted in minimal responses from the women. Most of the health professionals utilised local knowledge resources – stories and metaphors and hypothetical instances – to simplify technical ideas (HP1, HP2, HP3 and HP4). Most of the health professionals employed humour with some teasing (HP1, HP2, HP3, HP4 and HP5) and occasional laughter was observed, while only one health professional adopted an observably serious tone (HP7).

As demonstrated in Chapter 4 (Examples, 4.5, 4.6 and 4.7) there were some attempts by the health professionals to collaborate with the clients in the reproduction of knowledge at the micro level as they built on each other's talk. There was an effort to 'share labour' (collaborate) in the information delivery between the clients and the health professionals. The study has shown that the health professionals claim to operate within an apparent ethos of client-centredness by explicitly encouraging the women's participation in the talk. However, clients have demonstrated that they have prior knowledge that they bring to the talk as they answer the questions during the sessions, making the sessions a forum for collaborative talk rather than unilateral presentations by the health professionals. Through these strategies both the health professionals and the clients have demonstrated that knowledge reproduction in this context is a collaborative activity whereby the women responded to questions and asked questions, while the health professionals built most of the talk based on those questions.

The strategy of using questions and answers in an interview format is a mode of communication that for some time has been found to result in a joint information delivery in HIV/AIDS consultations between clients and counsellors (Peräkylä and Silverman, 1991). A number of studies in interactional sociolinguistics have attested that in medical encounters participants are engaged in joint activities, such as co-constructing or co-producing patient narratives (Heritage and Maynard, 2006; Vickers et al., 2012), hospital safety operations from patients' narratives (Doherty and Saunders, 2013), knowledge of illness and the medical institution (Candlin, 2006). However, although there was collaboration at the micro level of the talk the study does not ignore differential power relations between the medical practitioner and the patient and their knowledge differences, but recognises that even such distinctions in medical encounters are co-constructed between the participants. For instance, it has been demonstrated in other studies that patients' passive role in the interaction (Heath, 1992) or their knowledge of the illness (Candlin, 2006) are jointly constructed with the medical professionals. Thus, the question of enactment and negotiation that interactional sociolinguistics highlights comes into the limelight: that it cannot be concluded that the discourse strategies achieve client-centredness or prevent it but that these are enacted differently by the participants in the talk.

All the health professionals in this study demonstrated the effort to collaborate with the women in reproducing what is known about HIV/AIDS, albeit with interactional asymmetries due to the expert control that the discourse strategies such as questioning reflect. Another study has shown that, even with such power differences, health professionals working in therapy make the effort to involve their clients by drawing their talk from the clients' responses and narratives (Buttny, 1996). As an example, use of question and answers in the study has both a positive and negative effect on participants' relations: question and answers are believed to align the client and the counsellor or health professional (Silverman, 1997) as both are involved in the activity of exploring their knowledge in the interaction. In this case the questions and answers have a pedagogic value, that of involving the clients. From another perspective, the use of question and answers or the interview format in counselling and medical interaction in general are said to reinforce asymmetries in power. The questioner has more control than the answerer as they steer the conversation in keeping with the goals of the medical institution (Ribeiro, 1996), and it has been argued that questioning is one strategy used by those in power to exhibit their power (van Dijk, 1993).

Thus, although the participants' collaboration in the reproduction of knowledge was demonstrated in the interaction, the talk revealed various distinct forms of knowledge which, in turn, reflected complicating asymmetries of power among the participants. The interaction revealed the complexities in these forms of reproduced knowledge as they were negotiated interactively among the participants. Consequently, these findings point to the questions concerning the place of local and experiential knowledge in the medical discourse. To elucidate the position of different forms of knowledge in the discourse, a discussion of the interplay of knowledge forms negotiated in the talk is conducted before relating the negotiation of these knowledge forms to the agency of the participants later in this chapter.

7.3.2 Negotiation of knowledge

Of central importance, as was raised in the research questions, is how knowledge, and in particular, different types of knowledge, were negotiated by the participants. Negotiation of knowledge is important if client-centredness in the counselling sessions is to be achieved (e.g. Penn et al., 2011). It has been found that there were different forms of knowledge from the interaction: local, common-ground, presupposed, experiential, medical (specialised or common) and legitimate. There were complex activities in the observed interaction brought about by the interplay of various systems of knowledge, for example, medical and local knowledge or medical and experiential knowledge. There is medical knowledge which was reproduced by participants in the talk, as "a regurgitation of instruction" (Higgins, 2014: 722) comprising legitimate knowledge (after Bernstein, 1996) that the clients obtain from prior interactions with official health information sources. There was also local knowledge, which both the health professionals and clients reproduced in distinct ways, such that it was noted that the reasons participants in the discourse refer to local knowledge differed between the medical professionals and the clients. As demonstrated in the analysis, some of the health professionals (for instance, HP1, HP3 and HP4) brought in local and common-ground knowledge in the form of stories, metaphors and analogies to elucidate technical terminology. For example use of local knowledge in metaphors for medical concepts that the women could relate to, such as *chishango* (shield) for condom; torn *nsengwa* (winnower or sieve) for cervical membrane in relation to HIV transmission in the womb.

On the other hand, the clients in the counselling sessions brought in local knowledge which challenged, resisted or problematized the claims of the medical institution, such that the local knowledge emanating from the women revealed some tensions with the medical knowledge. Studies of HIV/AIDS discourse and other health themes have shown the effect of conflicting knowledges between medical and indigenous or local discourses (Drescher, 2010; Higgins and Norton, 2010). Interactional challenges arising when there is a mismatch of medical expert knowledge and patients' knowledge have also been demonstrated in a study of paediatric consultations by Tannen and Wallat (2006). These authors show how mothers oriented to the gaps between their knowledge and that of medical experts by asking questions, while medical practitioners directed the conversations to achieve their medical goal. In Malawi it has also been shown that interventions of HIV/AIDS have mostly been hampered by these competing discourses; for instance research on sexual reproductive health services for adolescents in rural Malawi alludes to knowledge gaps that occur due to differences in beliefs, conceptions and prevention strategies across religious and community organisations to that which is held by the official organisations (Jimmy-Gama, 2009).

This tension of knowledge that emerged among the participants pointed to the importance of paying attention to the different forms of knowledge that clients have in HIV/AIDS discourse. By revealing such tensions, this study contributes to making health professionals aware of the disjunctions of knowledge that may affect patients' reception of care while also making them aware of the strategies that should be reinforced (e.g. Slade et al., 2008). Particular strategies to reinforce are the integration of both local knowledge and the patient's world into the talks. For instance, it was noted from the data that where evaluative questions were raised by one health professional (HP3) it led into a lengthy discussion, for example on challenges of using condoms (Chapter 4, Example 4.3). Thus, the questions and comments raised by some women in the resulting discussion represented the voice of the social world that potentially challenges the medical knowledge. In particular, some women raised the limitations of an HIV infected woman who collects condoms in order to do "as the hospital requires" (Example 6.3, line 21) but is then faced with lack of cooperation from her spouse; in this case, the knowledge that the women have is understood not as conflicting with medical knowledge but as a shortcoming to its application.

By the nature of their questions, the clients were directed to state particular forms of knowing that were ratified by the health professionals. In this case there was a synthesis

of official knowledge with local knowledge to relate the information in ways that could be understood. However, the analysis revealed that the type of local knowledge that is acknowledged to be relevant, or even legitimate, to the medical knowledge was filtered. The analysis has illustrated that women largely raised the information which was appropriate in this forum, as directed by the health professionals' questions, while other forms of knowledge were resisted (e.g. Example 6.5). This gap in knowledge sharing and ignoring the local voice in participation is raised in a review of literature on Malawi by Chirwa (2010) in which she argues that, although there are establishments to ensure local participation in the areas of HIV/AIDS in Malawi, the extent to which local community members are permitted to participate in interventions, decision making on interventions and service delivery, remains a challenge. Nevertheless, others elsewhere in Africa argue against clear divisions between knowledge forms that what is considered local knowledge, over time, becomes the official or global knowledge through 'hybridity' and 'adaptation', hence not as clearly distinguished (Higgins and Norton, 2010: 9; Canagarajah, 2002). The interception of local knowledge and the official or medical knowledge about HIV/AIDS is one point of interest that is demonstrated in the analysis of interaction of knowledge forms in this study. It has been shown that there were challenges arising in the discourse due to the negotiation of the place of local knowledge in medical knowledge. Achieving such a balance where different systems of knowledge are reconciled is desirable but has remained a challenge in this context.

This analysed data showed the complex nature of the negotiation of knowledge, and its relationship with social practices and social institutions. That is to say, there were practices in the social context that facilitated the interaction which took place at the micro level, such that it was observed that negotiation of knowledge was happening but it was not straightforward. Some of the discourse strategies used in negotiating and reproducing the knowledge by the participants involved recontextualisation of knowledge, particularly evidenced by intertextuality, whereby texts of other genres enter the spoken text (Fairclough, 1992: 39; Hodges, 2015; after Kristeva, 1980). Through the dynamics of intertextuality, participants brought in various voices which were sometimes competing (Examples 5.6 and 5.7). The interplay of knowledge forms is also addressed in a UK study of medical interaction (MacDonald et al., 2009), in which a medical interview is considered a convergence zone of shared group knowledge of the medical professional and common-ground knowledge of the patients; that there are discursive processes whereby one type of knowledge can be transformed to another,

for example, “private, personal knowledge of the patient into interpersonal knowledge shared with the medical professional” (p. 199).

The clients’ responses to the health professionals’ questions and comments amount to a form of intertextuality, as they not only reproduced medical knowledge but also the beliefs and practices that they hold towards it. Several social practices were realised in the talk, those that are to do with the women’s everyday lives such as: following expert advice, protecting children, taking care of the self, taking care of the family, and relating to the spouse. These practices were linked to different social institutions such as that of the home, community, or hospital. In turn the institutions denote relevant social relations such as, of husband and wife, father and child, mother and child, mother and health expert. So, the participants, as social actors interacting in this context, brought in the voice that realised their social world and social relations, and they utilised established genres to reproduce these voices (see Hodges, 2015).

From the medical interaction analysed, therefore, it was demonstrated that there are gaps between ‘local patriarchal practices’ and ‘medical knowledge practices’ and these gaps were negotiated intertextually. Similarly, by focusing on recontextualisation, van Leeuwen (2008) has argued how, in interaction, the texts of one context are transformed and appropriated into another specific context; moreover, as the participants recontextualise social practices they are also involved in legitimisation of these knowledge practices (after Bernstein, 1996). Legitimation of the social practices involves the strategies that the participants use to enable certain discourses to enter a given text, for instance by making reference to expert authority, and government regulations on testing pregnant mothers as institutional backing for the practice of taking the test (van Leeuwen, 2008). An example of this type of legitimation in this study was achieved as the women are asked to provide the reasons behind having the HIV tests or for preventing the baby from infection (Example 5.1) where they gave responses such as “to protect the baby we are expecting” or “by reducing number of partners and also to get tested frequently”. This exchange provided the participants with a chance to include ‘personal authority’ as a legitimation of acceptable practices, and in turn, they delegitimised those that were not in line with medical practice, such as failing to use a condom due to asymmetries in power relations with their spouse.

This exploration of different types of knowledge in the discourse has demonstrated that cultural and local knowledge has a place in the HIV/AIDS discourse but its position

shifted according to the extent to which it complemented the authorised medical discourse. This is in line with what was demonstrated – that by using metaphors and stories the health professionals suggested that there are positive relationships between the two systems of knowledge (Examples 5.3 and 5.4); however, a closer look at the women's contributions drawn from local and experiential knowledge revealed that this relationship is not straightforward. Some of the health professionals utilised discourse strategies that reflected selectivity in information, in that they reinforced existing official knowledge about HIV/AIDS while sometimes they blocked other contradictory forms (Examples 6.3 and 6.5).

So, describing the relationship between knowledge systems in terms of their degree of compatibility, it can be argued that in this context cultural and local knowledge were recontextualised differentially on a continuum of their congruence with medical knowledge, with one end of the continuum representing total congruity and the other end representing total incongruity. As demonstrated in this study some aspects of local and experiential knowledge are incorporated to describe the medical knowledge while some knowledge forms that contradict medical knowledge are excluded, thereby perhaps exhibiting an extreme degree of 'incongruity'.

The participants negotiated these different forms of knowledge with an orientation to the complexities created by asymmetries of power within the social and institutional structures, thereby reflecting a complex link between knowledge, power and (participants') agency. It has been demonstrated in Chapter 6 that these social and institutional structures result in the variability of the clients' agency in this discourse of HIV/AIDS. The question of "how knowledge about HIV/AIDS is negotiated and reproduced by the participants in this context" is therefore addressed by stating that although local cultural discourses were permitted there was a limited prevalence in the counselling sessions. It therefore appears that it is the official form of medical knowledge that is, 'in the last instance' (after Althusser, 1967), accorded legitimacy and, therefore, accorded power in the counselling sessions.

By employing a micro linguistic analysis on the interaction it was revealed that the women were involved in negotiating knowledge, but its extent depended on the health professionals and the type of knowledge. This shows that power of the institution is not only constitutive of the discourse but is also enacted by the participants in the discourse.

The implications of the reproduction and negotiation of knowledge on participants' agency is discussed further in section 7.3.3.

7.3.3 Agency of the participants in the reproduction and negotiation of knowledge

This section reveals how tensions between knowledge, and individual agency in applying that knowledge, were negotiated in the talk. Both the health professionals' and the women's responses showed agency in their discursive practices but these were in varying degrees. The variations that were noted in the data imply that application of the results are not 'one size fits all', but would need to take into account the existence of individual variabilities in the communication strategies. The women's agency in the discourse was considered at two levels: agency during the interaction, and agency in actual everyday practices, as realised in the talk. When the women went beyond the reproduction of existing legitimate knowledge to share their experiences, ask questions, and comment on the topics raised in the talk – drawing on their local experience – then this gave them the legitimacy to exercise their agency in the talk. There were instances when a question prompted the women to discuss an issue, (Chapter 6, Example 6.3) where they relate their experiences – cultural knowledge – and in such cases their agency was enacted. Questions are said to be rare in counselling in antenatal clinics as clients have a fear of speaking up and addressing questions to health providers because of respect and power distances (Donahue et al., 2012; Evans and Ndirangu, 2009); and during interviews some women in this study alluded to the choice they made of being silent and not asking questions, especially because of the restrictions of being in a group.

By adding to what the health professionals said, some of the women added unelicited comments (Example 6.4), laughter and some even asked challenging questions (Example 6.3) to indicate the challenges that such social practices brought to the application of medical regulations. With such discoursal features some of the women signalled not only how knowledgeable they were, but also that they possessed the capability to evaluate the medical information against their local knowledge.

The data therefore suggested that the women exercised their agency in part; on the one hand they drew on local knowledge to come to grips with the medical knowledge, on the other hand they were constrained by the institutional regulations on the discourse. It was also observed that the agency of the participants in the talk seemed to vary with

the nature of topic of discussion: the agentive roles varied from that of the individual to that which involved an outside 'other' or a "semiotic agency" such as the medical institution (Moore, 2005) when they referred to "government regulations" for example (Example 6.1).

These variations in style are addressed in one study that asserts that the sequence of imparting knowledge by health providers to patients differs and is treated differently by different actors because a form of negotiation between the participants takes place (Stivers, 2006). According to Stivers (2006), sometimes patients may respond positively or show passive or active resistance, which alters the structure of interaction. Where such resistances and affirmations occurred – which are the processes of negotiation of knowledge – most of the clients' participation in reproduction of the knowledge in this study was observed to be active.

Some of the health professionals' agency in altering the strategies of the counselling sessions from what was stated in the protocol of HIV counselling influenced the women's agency to participate in the session. It was noted in the analysis that various discourse strategies appeared to influence participants' agency in positive and negative ways. The discourse strategies such as the question and answer forms – also referred to as the interview format – were an expected format (Peräkylä and Silverman, 1991), yet the individual styles of storytelling, use of extended metaphors, and humour utilised in the talk by various health professionals worked to encourage the women's participation interactionally and reduced the effects of power asymmetries (see also Chimbwete-Phiri and Schnurr, 2017; Chimbwete-Phiri and Schnurr, forthcoming). Such utilisation of local knowledge demonstrated a strategy that was not explicitly given in the counselling guidelines. This inclusion of spontaneous material demonstrated the agency of the health professionals to enrich the talk. Unlike this study where the counsellors adapted the topics in creative ways, one study in rural Kenya reported how counselling was observed to be very generic across health professionals and sounded scripted (Ndirangu, 2016).

It therefore implies that in the current context there is potential for the health professionals to adopt more creative ways that could accommodate conflicting discourses and those discourses that exist outside the guidelines. Similar success of the discourse strategies, i.e. individual styles of the traditional interview-formats, have also been demonstrated in a study where they resulted in nurses understanding of patients'

narratives and entering into the patients' lifeworld and culture (Candlin, 2006). In the current study however, the success of the strategies varied according to health professionals where some adopted more formal formats of question and answers (e.g. HP4), while others were more creative with the style of questions by asking more evaluative questions (HP1 and HP3). For example, in such cases the responses of the women tended to be more participatory in that they included other knowledge forms beyond the legitimate form of medical knowledge.

In other instances, by being agentive in structuring the talk, some health professionals demonstrated the tension between the protocol of counselling and their local knowledge. For instance when some health professionals criticised the women about their social behaviour, i.e. lacking agency in decision making by relying on husbands (Example 6. 4); lacking agency in condom use (Example 6. 2); and for failing to convince their husbands to go for a test (Example 4.1). These were instances of the health professionals' awareness of the women's weakness and they took a moral responsibility to advise and criticise the women using a tone that diverted from the standard protocol. This way, the health professionals drew on their knowledge of this cultural context as a discursive resource within the institutional context.

Analysing the micro details of the talk therefore illustrated that although power was enacted by most of the health professionals, occasionally, it was also enacted by some of the women. However, the enactment of power by the women varied according to the agency of the individual women to challenge the talk, i.e. the institutional structures were, to an extent, oriented to in the discourse. In the analysis of examples, it was seen that sometimes the role of the health professionals reflects that of activists, encouraging the women's agency, and in that way they represent a discourse of "empowerment" (see also Finn and Sarangi, 2010; Seidel, 1993); at other times they seem to represent the demands of the institution which have been shown to sometimes not match the social realities of the women. At the same time, the institutional responsibilities of promoting health appear to regulate the health professionals to relay medical recommendations regardless of the clients' resistance. This resistance is what others have referred to as a "rights discourse" (Seidel, 1993: 175) as it reflects the clients' disadvantaged position in the social structure.

Consequently, by negotiating knowledge in the talk it reflects the participants' agency not only during the interaction but also signifies how the social structures influence their

agency to act within their social practices. Section 7.4 will elucidate the implications of the relationship between social and institutional structures on participants' agency as derived from the observed interaction (micro context) and the social and institutional context of HIV/AIDS health care.

7.4 Relationship between institutional structures and agency of participants

The second question that the study addressed is:

> What is the relationship between social and institutional structures and participants' agency in the reproduction and negotiation of knowledge in the healthcare context in Malawi?

By analysing the participants' discourse the investigation revealed that there are social and institutional structures that the study participants oriented to in the interaction. And the study indicates that it is in the interaction that the broader social and institutional structures are reproduced (Candlin et al., 2017; Waitzkin, 1991). And by examining the institutional and social context of the talk practitioners can make informed adjustments, for example as they reflect on their practice (e.g. McIntyre et al., 2012; Smith, 2007). The first element to explicate is the relationship between the agency of participants and the social structures in this reproduction and negotiation of knowledge.

7.4.1 Relationship between agency of participants and social structures

The first aspect to focus on is that of social practices which influence health related decisions and actions for the clients. Analysing multiple layers of discourse with the inclusion of broader social structures, as done here, was useful for mapping the structures around the discourse of HIV/AIDS which are oriented to in the discourse of care and recognising the actors involved in order to guide practitioners and researchers. The usefulness of this analytical approach is evidenced by Smith (2007) who by using CDA approaches identified structures to debates on the roles of nurse practitioners in Australia in order to inform policy makers and practitioners on how to negotiate the resulting tensions.

The findings of this study have revealed that HIV/AIDS discourse in this context reflected gendered challenges. The results showed how the women expressed social restrictions when they reacted to the health professionals' recommendations. From the women's talk the husband was constructed as the one exercising power over the woman, for instance when it comes to decision making about condom use (Examples 6.2 and 6.3). This alluded to a wider social practice that culminates in unequal social relations, lack of autonomy for the women in using condoms to protect themselves from further infections or conception, and the women's failure to act autonomously to protect their babies from HIV infection. The women raised these social problems inasmuch as they referred to the challenges they face at home when they encourage their spouse to go for an HIV test or use a condom in the case of infected couples, which suggests that the demands of the medical institution and their social responsibility as wives present a contradiction between following hospital recommendations and adapting them to their needs.

The women constructed themselves as having agency to act upon the given information, by collecting condoms for instance, but they were challenged by their husbands' resistance. As has been observed, going to the clinic, participating in the counselling sessions, and undergoing the test, is evidence of the woman's agency. By consulting the health professionals, they enact the responsible patient, while they grapple with the responsibility that follows being diagnosed HIV positive, i.e., to comply with treatment regulations for their own health, that of their unborn baby and that of the husband (since they are expected to bring the husband for a test). However, their agency is simultaneously hampered by the existing social inequalities that position the women at the bottom of the decision making ladder (Berendes and Rimal, 2011).

The role of the husband, as a prominent actor in this antenatal discourse, was raised a number of times in relation to condom use, adherence to medication and prevention of infection, for example, in terms of utilisation of treatment regimens, whereby some women depend on their partner's decisions to proceed with treatment or they fail to convince their partners to go for an HIV test. Consequently, some women do not disclose their status to partners for fear of divorce and the economic challenges associated with it (Njeru et al., 2011; Obermeyer et al., 2013; Flax, et al., 2017). Interestingly, in a study in one district in Malawi, PMTCT was referred to as a 'divorce programme' because a significant number of women in a certain community were abandoned by their husbands after disclosing their HIV positive status (Njunga and

Blystad, 2010). In another study it was also found that women feel the pressure of PMTCT on them and wish that husbands were forced to go for tests as well (Hardon et al., 2012). However, with the spouse being absent from the counselling sessions only women are said to have frequent contact with healthcare providers, thereby having a higher knowledge of preventive and treatment practices than men (Jimmy-Gama, 2009).

These existing social practices were realised in the talk of the health professionals as they criticised the women and appealed to them to act with autonomy in the face of their partners' opposition to the treatment decisions that they make (Examples 6.2 and 6.3). However, the health professionals' talk in this case may not be so significant if the social structures remain unchanged. The effect of social structures on the enactment of agency by patients has been argued that although "the people know how one gets infected" and how to prevent HIV, the challenges they face are not of lack of knowledge but of the practicalities in applying that knowledge (Chasi and de Wet, 2006). Chasi and de Wet (2006) argue for the need to give people freedom to choose how they act upon the information about HIV/AIDS by considering their individual agency and material conditions. Just as in the current case, the knowledge forms may not necessarily conflict, over time; due to the widespread health promotions in the sub-Saharan region people know what they ought to do but being subordinate in the family, the women may lack the capacity to act upon this knowledge (Jones and Norton, 2010).

In this specific context of HIV/AIDS, the women were willing to be tested, they realised the importance of protecting the baby, but some of them expressed powerlessness to act upon their knowledge because of patriarchal structures. This is similar to what Montgomery et al. (2006) found, in their study of malaria consultations between health providers and rural mothers in a low literacy context in Tanzania, that mothers were knowledgeable in terms of malaria symptoms and what they had to do for their children, but contextual factors such as lack of independence in decision making and financial constraints prevented them from seeking medical care on time. Hence, the discourse of health care was demonstrated to go beyond the micro aspects of talk but is affected by broader social structures.

The discourse of the women, though, which appeared to be granted inadequate attention (as illustrated in Examples 6.3, 6.4 and 6.5) in this interaction, attested to the need for attention to social context and individual factors in HIV/AIDS care. Introduced by Mishler (1984) the concept of paying attention to the patient's life world in medical

interaction has been the attention of discourse analysts in health care for a long time (Candlin, 1995; 2006; Clark and Mishler, 1992; Haith-Cooper and Bradshaw, 2013). In the context of HIV/AIDS care, this has been demonstrated by a study of pharmacists in ART clinics in South Africa who sometimes ignored the knowledge of context and social world of patients, such as social economic difficulties and medication side effects that the patients presented during interaction (Penn et al., 2011). Another related study has also shown that there is a direct link between the micro elements of interaction and the macro context, in the context of ART adherence counselling in a South African clinic, by illustrating how from patients' narration, contextual factors that are beyond medical knowledge are extracted (Watermeyer and Penn (2012). Thus, patients may understand the need to take medicine, and the implications of skipping it but because of socio-economic issues some patients skip it, yet their narratives were ignored by pharmacists (Watermeyer and Penn, 2012).

Ignoring clients' discourse, as was done in some of the cases in this study, points to the relevance of the dialectical view of discourse in CDA – that micro structures shape the macro structures and also in turn are shaped by the macro structures – (Fairclough, 1992, 2010). In the current study there was no clear evidence to show that the participants' discourse at the micro level of talk has the power to change the discourse at the macro level, inasmuch as the discourse at the macro level shapes that of the micro level. As demonstrated there were a few indications by some of the health professionals to accommodate the women's discourse (e.g. Example 6.1) and attention to the women's other discourses varied from context to context. The inadequate attention granted to the women's discourse was proliferated by asymmetrical power relations between the women and the health professionals who are the agents of the social institution. The effects of power relations on the HIV/AIDS discourse at the hospital – as a social institution – are explored in section 7.4.2.

7.4.2 Relationship between agency of participants and institutional structures

This section will discuss how the health professionals' power, institutional regulations pertaining to ethical dimensions of HIV/AIDS counselling and testing, and the clients' social position in the community affect clients' agency interaction. Institutional structures, such as deontic responsibilities and power of health professionals and the hospital as the regulating institution, have a bearing on the type of interaction that takes place. It was stated that health professionals in the study claimed to deploy patient-centredness as a principle of counselling in HIV/AIDS clinics and explicitly used linguistic strategies to involve the women in the discussion. However, there were contradictions in some of the discourse strategies they utilised and consequently seemed to silence the women. These contradictions may be a result of dilemmas that some health professionals are said to have in HIV/AIDS clinics in sub-Saharan Africa, such as achieving client-centredness and patient autonomy in decision-making and at the same time ensuring patients' compliance with treatment. Health professionals in HIV clinics are meant to follow a model referred to as the '3Cs', where the emphasis is on *C*ounselling, HIV testing to be preceded by informed *C*onsent; and *C*onfidentiality (UNAIDS, 2004). A number of studies have shown how health professionals in sub-Saharan Africa are challenged to follow this model of counselling in full because they are also mindful of cultural dimensions in which they operate (i.e. patriarchal structures that restrict women's independence in decision making) (Angotti, 2010; 2012; Evans and Ndirangu, 2009), to the extent that some of them are said to operate within contextual norms that lead them to merely adapt the model with cultural sensitivity (Angotti, 2010).

It is believed that the talk itself may be amenable to agency but clients' agency is limited by the institutional and social structures at the macro level of discourse. The effect of institutional structures, such as hospital guidelines and health professionals' role in interaction, may be directly related to the introduction of provider initiated counselling and testing, with an opt-out model, such as that carried out in the antenatal clinics in Malawi. Some scholars have shown that in some African settings there is a tension between patient voluntariness and health professionals' coercion (Evans and Ndirangu, 2009; Monjok et al., 2010; Njeru et al., 2011). These contradictions between the need for clients' agency and applying institutional regulations may explain some of the cases whereby agency enacted by the women during the interaction was sometimes resisted by the health professionals. This way the health professionals demonstrated epistemic

power by controlling any diversion of topics and sometimes resisted unelicited comments and questions, thereby reinforcing their roles as experts while reinforcing the subordinate role of the clients.

Power of the institutions in diminishing participants' agency is attested to by some scholars who suggest the controversial nature of provider-initiated testing and counselling (PITC) in antenatal clinics and loss of voluntariness for patients; they observe that patients feel coerced because they cannot refuse advice from health providers (Monjok et al., 2010). Another study reports how HIV counselling approaches in Kenya were fraught with the dominance of unilateral communication and a mere health promotion by counsellors (Ndirangu, 2016). Furthermore, this study has found that clients' need for informed consent was not mentioned explicitly, rather women were addressed in relation to the need to follow government regulations to protect the baby (Example, 6.1). The influence of institutional and social structures was evident in this tension between the discourse of voluntariness and coercion. It was evident that there are institutional structures that were enacted in the talk whereby the health professionals in the study sometimes oriented to government regulations, thereby legitimising their position as health professionals and their role as experts, and at the same time constructed that of the women as less agentive. As the clients were relegated to a passive and subordinate role of listening and reproducing the legitimate HIV/AIDS discourse, it in turn constructed the expertise of the health professionals (also observed by Atkinson, 1977, 1995).

Sometimes some of the health professionals explicitly used the language of power for example, "the actual issue here is that a pregnant woman is required to have her blood tested, whether she wants it or not" (HP5). The style of counselling in some cases sounded reprimanding, thereby defeating the need for client informed consent and freedom to opt out. These power asymmetries in interaction are linked to the power of social institutions in some African settings, for instance, Angotti (2012: 336) has revealed how the global health model of individual and human rights on disclosure and choices to have an HIV test differ from those of 'estranged' contexts such as Malawi. Her study illustrates the culture of sub-Saharan Africa where community and social obligations prevail over individualism even on health matters (Angotti, 2012). She also observes that HIV counsellors do not embrace the model of counselling and testing uniformly but adapt the situation according to what is appropriate at a given time, for example, by encouraging clients to be tested, despite their unwillingness, and

sometimes disclosing a client's blood test results to a partner or care giver claiming it to be for the patient and family's own good.

The ethics of HIV testing and counselling are said to be in conflict with the health professional's "sense of morality" as such HIV counsellors "bend" the guidelines (Angotti, 2010: 992) to prevent harm to the clients and their families. In some cases, the clients' agency in making autonomous decisions and participating in the discourse was restricted by the priorities of the social institution. The relations of power between institutional structures and participants' agency in HIV/AIDS discourses is also attested to in one study conducted among the working class in a North American context in which clients' stories, i.e. disclosure of HIV status to spouses and peer educators, were examined and found to be shaped by institutional processes (Leonard and Ellen, 2008). The HIV/AIDS institutions constructed patients "subjectivities", whereby access to certain care interventions appeared to have implicit conditions ,such as disclosure of status to others (Leonard and Ellen, 2008).

The effects of social institution over the clients' agency defeats the ethos of client-centredness called for in the HIV/AIDS counselling guidelines for this context. This relates to what Watermeyer and Penn (2012: 609) refer to as a conflict between "principles of beneficence and autonomy" in sub-Saharan Africa clinics. Such a conflict is said to be the reason behind the sometimes authoritarian interaction that challenges client's agency and autonomy to choose. The ethos of patient-centred care in HIV/AIDS care is a paradigm shift from that of a relationship of trust, where health providers would give medical advice and instructions. Thus, a health institutional model common in sub-Saharan Africa is demonstrated as paternalistic and authoritarian whereby the roles of provider and patient are clearly defined leading to deference by the clients and this is challenged by the culture of rights and patient-centredness that HIV testing global recommendations stipulate (Angotti et al., 2011; Evans and Ndirangu, 2009).

The study did not find any evidence of negative reactions to the powerful institutional structures over the women's agency during interactions. During the current study all women who were in the counselling sessions underwent the HIV test, and received their results. In addition, from the interviews, all the women indicated that they found it important to take the test, with several women reproducing an HIV test campaign slogan: "knowing your HIV status is more important than not knowing". It was also learnt from the interviews that no woman had any concerns with the counselling styles

of the healthcare providers and some said they had enough opportunities to ask questions (although the analysis has shown that this was not always the case). This was also confirmed in another Malawian study in which, despite being 'coerced', pregnant women in PMTCT programmes consider being HIV tested as an important part of the services aimed at helping the baby and the mother (Angotti et al., 2011). The women's responses led to the observation that, by enacting expert knowledge, the health professional is constructed as having power (see Fairclough, 1992) and such enactment of expertise and power seemed to be desirable in this current context. The relationship of power and knowledge on agency of participants is further elucidated in section 7.4.3.

7.4.3 Agency, knowledge and power

The analysis of interaction and interview data demonstrated that elements of power relations, knowledge and agency in this healthcare site are not static but vary with context (e.g. the clients and health professionals involved). To some extent there were shifting roles and agency of participants in the talk, which resulted in shifting power relations. These shifting power relations were in evidence first through strategies of solidarity and collaboration in discussing preventive practices (Chapters 4 and 5) and some distancing strategies (Chapter 6). Thus the clients and health professionals in the study oriented to power structures, then reinforced and sometimes negotiated them.

This negotiation process in healthcare encounters activity is also attested by Stivers (2006) who shows how parents in a paediatric ward were involved in negotiating their position in treatment decision, either passively or actively. In another study the shifting and negotiated power is also shown to be fluid, for example where the patient's style of presentation is co-constructed but in the end the physician still had power to direct patients' presentation towards the institutional goal (Heritage and Robinson, 2006). In this analysis of counselling, some of the women enacted their power in the discourse as they raised practical challenges and concerns; however this power was, to a large extent, temporary as the health professionals redirected the talk or reformatted the discussion to 'teach' and advise the women.

These shifts in power demonstrated the enactment of agency for both participants at the micro level and restrictions that were influenced by discourses at the macro level, such that the effects of macro social structures on interaction also reflect conflicting roles that health professionals in Malawi and other contexts in sub-Saharan Africa have

within the healthcare interaction. There is a complexity of roles as the health professionals act as 'intermediaries' between the global or national HIV interventions and the locals who access them (Angotti, 2010). In cases such as those of the current study, the health professionals in HIV/AIDS clinics, most of whom were also community health workers and nurses, lived in the communities and participated in some village activities. Being members of the same communities as their clients, they sometimes share similar experiences, sometimes a similar religion and respect for family ties; thus it is sometimes not easy to distinguish their roles as professionals (Angotti, 2012; Zulliger et al., 2014).

This complexity of roles is similar to what Sarangi and Roberts (1999) refer to as distinct modes of talk that a professional can present in workplace discourse – professional mode, personal experience mode, and institutional mode, i.e., the health professionals may have this blend of experience as members of the medical profession, as representatives of the institution, and as members of the community together with that of the clients. Similarly the analysis of data provided evidence on how health professionals in this study seemed to orient to their membership and roles in different groups: acting as members of the HIV/AIDS institution and a voice of the medical world, and belonging with the women and sharing their concerns (as a voice of the lifeworld). In contrast, by criticising the clients, the health professionals enacted their institutional power as medical agents with a responsibility to question incorrect social behaviour and position the women as the subjects.

The variation in roles of the participants in this study appeared to reinforce the distinctive systems of knowledge that are shared between the women and the experts (Fairclough, 1992: 12). But what is said to happen in forums of knowledge transmission such as this, is that as the knowledge is becoming contested, the ones with power gain an upper hand to control the forms of knowledge that are relevant in the given context (Fairclough, 1992), although it was evident that the health professionals operated within epistemic limits of the institution (see Wetherell et al., 2001) with its focus on the dominant knowledge of medicine as seen in the interaction. Furthermore, it was shown that by negotiating the various discourses in the talk the participants constructed the institutional values as more legitimate than the social values, because the tension between the two has remained unresolved or overlooked. Within the dialogic engagement and negotiation, the knowledge seemed to revert to the 'authorised version' or the legitimate form.

Enactment of agency by the participants in the study was influenced very closely by the social relations that are defined by institutional structures. Since as participants interact, through their language, the context, identity and meaning are enacted (Gumperz, 2001), similarly, as the women respond to the health professionals' questions their passive and active roles in the interaction was enacted. Furthermore, as the participants negotiated knowledge, they also discursively negotiated social relations, power and their identities (Fairclough and Wodak, 1997; Wodak, 1997). At the micro level of interaction, the roles of the participants and the elements of power relations were discursively constructed. The roles of the participants, as a discursive construct, is demonstrated in a study in genetic counselling into how nurses' varied roles and identities as counsellor or co-decision maker were co-constructed between them and their clients (Zayts and Schnurr, 2014). The health professionals as the experts were discursively constructed as the participants asked them challenging questions and responded to their questions (also Hall, 2001) and in other cases the authoritative nature of their role as health professionals was preserved (Heath, 1992) particularly when the women did not show resistance to criticism.

The study has therefore shown that the relationships between social and institutional structures and participants' agency in the reproduction and negotiation of knowledge in the healthcare context in Malawi are complex. The distinct voices in the analysed counselling sessions reveal that the relationships between participants' agency, power and social structures is a discursive construct. The power relations were negotiated at the micro level of the talk between the health professionals and the women, leading to varying degrees of agency being enacted. But the discourse also reflected institutional asymmetrical power relations at the macro level, for example those between the women and the institution as a regulative body, and between the women and society in general. The institutional practices and regulations of the clinic influenced the way participants reproduce and negotiate knowledge in that the health professionals were selective of what they accept from the clients' talk, revealing that to a large extent it is the 'legitimate' knowledge that is given prominence in the talk. The next section discusses the theoretical affordances of the analytical methods used in this thesis.

7.5 The methodology

The interactional sociolinguistics approach was useful for this kind of study because it enabled me to see the micro variability in which the talk is formulated, the specific relations of power and knowledge that are negotiated, and where power is located in the encounters. The strength of IS was to reveal the variabilities that exist among participants, thus showing that there are subtleties within the relations of power within the counselling sessions. However, with the view that discourse is constitutive of social relations (e.g. Angouri and Wodak, 2014; Fairclough and Wodak, 2010) some elements of CDA studies were also referred to because, as a supplementary approach, CDA enabled me to explicate the kind of relationship existing between the talk and the contextual social and institutional structures of HIV/AIDS. Drawing on some aspects of CDA, I have also been able to critique the institutional context and the way the institutional context creates and maintains power relations between participants.

It should be noted, however, that although CDA studies are also engaged with the specific aspects of talk, in my study, CDA was used principally to explicate the relationship between talk and contextual institutional structures. In this study IS was used to enable the analysis of the talk between the interlocutors in a more specific situation in which it took place, i.e., in counselling sessions, to unpack what was going on. CDA can also engage in the details of the talk, but in my analysis it enabled me to explain and critique the relationship of the talk to the wider institutional and social context outside the counselling sessions.

Thus, the study has utilised the framework of IS, with the support of studies in CDA, to explicate the view that participants are involved in interpretive and negotiative processes to make sense of the encounters in which they are engaged (after Gumperz, 1999), i.e., the relationship between the participants' agency in the reproduction and negotiation of knowledge and the social and institutional structures is discursive in nature. As participants are involved in meaning making processes at the micro level of discourse, different elements of discourse, for example, power, knowledge, and social and institutional identities and roles, are also negotiated (Candlin et al., 2017). As such, with a detailed linguistic analysis, as was carried out in this thesis, one can infer social aspects from the text through which elements of power are negotiated (e.g. Drew and Heritage, 1992). In this study, knowledge emerged as the focus of the negotiative

processes that participants are involved with in the interaction. Such that it was not just about showing that there is inclusion or exclusion of local knowledge in favour of medical knowledge but elucidating the type of local knowledge and the negotiation or reproduction processes involved.

7.6 Conclusion

The chapter has focused on the major findings of the study in terms of its conceptual, methodological and theoretical contributions. It has discussed the conceptual analysis of reproduction and negotiation of knowledge as an activity of the counselling sessions, and the relationship between the interaction that takes place and social and institutional structures in which it is embedded. Through the analysis of discourse it has been seen that, to a larger extent, there are power asymmetries existing within the social and institutional structures, which affect the women's agency to act based upon their knowledge. These asymmetries are manifested in the unequal relations between men and women, as well as power relations between the health professionals and the clients, and are oriented to and challenged in the discourse. The nature of such inequalities and their impact was only observable in the analysis of the discourse.

It has further been demonstrated that social and institutional structures do impact on the interaction that takes place between the participants. Although there is some agency that the clients have in terms of the local interaction that took place, 'in the last instance' the social and institutional structures determine the interaction (after Althusser, 1967). So this study concludes that there was restricted agency for the women in the negotiation of knowledge within the micro details of interaction.

As stated earlier, one of the central contributions of this study is to show the useful applications of the methods of applied linguistics to the study of medical discourse. By looking at the micro analysis, it shows the agentive aspect of the participants, as they affirm, resist and challenge the mainstream discourse. At a broader level of discourse however, it shows how institutional power and the social positions of the participants influence the interactional and discursive practices. The findings imply that in this discourse of health care there is the aspect of negotiation whereby power and knowledge are discursively reproduced and can be challenged (Fox, 1993; Norris, 2008; Ribeiro, 1996) and also a dialectical interconnection whereby language is determined by and

shapes societal ideologies and conditions (see Fairclough, 1992). However, the study has not found evidence, in its design, to demonstrate any effects that the interactions (micro discourse) have on social and institutional structures.

In relation to practice, the findings have shown the importance of understanding the clients' voices and incorporating other knowledge forms in the talk. It has been observed that presenting and delivering information or advising clients, are not the main activities of the counselling talk as also shown in other studies of HIV/AIDS counselling discourse (Peräkylä and Silverman, 1991; Silverman, 1997; Moore, 2005) but it is an exploration of the clients' voice in the form of discussions, which is a central activity in these counselling sessions. The clients and medical professionals may not share a common- ground because of the asymmetries in the power relationship; however, a dialogic approach that considers the various voices may facilitate meaningful discussions (Richards and Lussier, 2014). A discussion of the implications of these findings for the actual practice of counselling and education talks is detailed in Chapter 8.

Chapter 8: Implications of the study for health professionals

8.1 Introduction

This chapter finalises the thesis by explicating the implications of the findings for the practice of HIV/AIDS consultations and medical interactions in this study context and beyond. The previous chapter has shown that there is a tension between local and experiential knowledge of the clients, and medical knowledge, which is linked to the relationship between the talk and the institutional and social context of HIV/AIDS consultations. It has also described the findings in terms of their theoretical and methodological implications. The analysis of the discursive practices of the health professionals and the women clients has demonstrated that they collaboratively reproduced knowledge about HIV/AIDS. Furthermore, to some degree, the participants negotiated different knowledge forms about HIV/AIDS, while orienting to social and institutional structures that affect the clients' agency to act upon that knowledge. This empirical study has analysed and exemplified the shortcomings of some of the interaction at the micro level and constraints that exist at the macro level. These limitations and constraints have implications for the improvement of healthcare communication. The implications that I am developing in this chapter assert the benefits of analysing interaction between the health professionals and clients for the improvement of health communication at a micro level of discourse (e.g. Peräkylä and Silverman, 1991; Silverman, 1997; Vaughan et al., 2000).

The thesis has concluded that the current model of counselling and education, used for the prevention of HIV transmission from mother to child (PMTCT) in the institutional context of Malawi, has a reduced focus on the individual clients' needs as required in counselling (e.g. Hardon et al., 2012; Lettow et al., 2011). From the analysis, it was evident that the model included a number of desirable strategies that reinforce collaboration between the health professionals and the clients. While there was some effort to involve the clients and let them participate in the interaction, a greater amount of effort went into delivering information and offering them advice, as the health professionals covered most of the basic topics about HIV/AIDS as given in the guidelines or explained how the clients should follow medical procedures. For example, some of the health professionals undermined participants' contributions in the talk by

not giving adequate attention to comments and questions, which are described by one scholar as 'local funds of knowledge' and important (Higgins, 2014) and, as such, there were missed opportunities for topics that could have led to meaningful discussions. Furthermore, it highlighted that mere reproduction of knowledge, as observed in this study, does not empower the women (see Chasi and de Wet, 2006; Hall, 2006), and therefore this study suggests that it is imperative to focus on utilising a more participatory approach to healthcare communication in order to maximise the efforts of the PMTCT programme.

The data have shown a tension between the ethos of patient choice and client-centredness (as stipulated in the guidelines and what the health professionals claimed explicitly in the interaction and during the interviews) and its actual application during the interaction between health professionals and clients. Having looked at the micro level of interactions and how they relate to structures at the macro level it was seen that there are contextual aspects such as institutional power and unequal social relations that render the application of patient choice and client-centred care less achievable. Within the context of global ideologies of health care, such as those that characterise the Malawian context, there is the shift from passive patient to one who is empowered (McIntyre et al., 2012). Furthermore, the global health model stipulates ethics, human rights, equity, patient autonomy and choice, while the women as participants in this particular context, face the dilemma of meeting the healthcare requirements and, at the same time, resolving their lack of autonomy within the patriarchal structures (Buse and Hawkes, 2015). Within these values there are challenges that different contexts bring such that the data obtained here presents insights into how it is not just about following the protocol within the given values but that health professionals should reflect on the context, and how best to assist the clients in applying the knowledge. Similar observations are made by another scholar who believes that the HIV/AIDS biomedical approaches do not take into account the 'lived experiences' of those who live with the pandemic (Beckmann, 2013); she points to ignored social aspects in biomedical knowledge and argues that there is rationality behind some of the apparently irrational practices which the patients exhibit, hence need to incorporate them in medical discourse.

In contrast, however, other researchers have highlighted the challenges that health practitioners face in incorporating such clients' social issues in practice, for example, citing resource constraints and lack of capacity to focus on the social side of illness

experiences, and social structures that allow the provider control over the interaction (Waitzkin, 1991). But healthcare interaction is not just a way of uncritically following what the HIV counselling and testing protocol stipulates: "to discuss basic information" or regarding the ethical requirement as stated within the neoliberal ideology of health: giving people a chance to be "knowers", make informed decisions and granting them a responsibility over their health (Osborne, 1997). But there is a need to pay attention to context when applying such values (Dent, 2006). Hence, there is a need for a 'paradigm shift' from a universal package as given by the HIV/AIDS promotion messages to one that is tailor-made for resource poor and marginalised populations, such as that of the women in the study – especially if they are to benefit from sustainable development goals as suggested by the global forum of international development in the health sector (Buse and Hawkes, 2015). It is with these notions in mind that data obtained from this study presented actual evidence of interactional challenges during the counselling sessions and offered insights on how to achieve patient involvement and empowerment, as it appeared to be inadequate in the healthcare centre under study.

The findings of this study, therefore, imply a move from a mere reproduction of medical or declarative medical knowledge to focus on the procedural or local knowledge, and pay attention to the women's lived experience – experiential knowledge (e.g. Boardman, 2014). It is believed that the health professionals and the institution have something to learn from the women and, although the women may be placed on the receiving end of medical information, they have other contrasting information that needs responding to. Consequently, these findings point to the need to reconsider the mode of communication used within the education and counselling sessions within this context. This chapter, therefore, draws the thesis to a conclusion by describing how the findings could be applied in actual medical practices (at the micro level) and for the improvement of everyday knowledge practices of the healthcare clients (at the macro level), and it closes by making recommendations pertaining to future research endeavours. It will first summarise the intervention plan in section 8.2 before going into more detail.

8.2. Researcher interventions

The implications of the study discussed in this chapter project my personal involvement as a researcher to meet various stakeholders and engage in the activities as a facilitator or contribute to development of material where such suggestions are accepted. Subsequently, this section outlines my implementation plan for the suggested activities, which will be conducted upon my return to Malawi.

Implementation plan of the suggested interventions

a. Feedback given to the participating health professionals at Khokho health centre and a copy of the summary of key findings of the study will be made available to them. This will be done in the form of workshop and focus group discussions.

b. Seeking an audience with health officials at the district and Ministry of Health level to disseminate the research findings and seek consultations to develop the intervention programmes. This will be done in the form of seminars.

c. Seeking collaboration with advocacy organisations that promote health, rights and women empowerment (e.g. Kreps, 2012).

d. Identifying participants' education needs through conversations with health professionals, community health workers, general population, and hospital clients. This will be done through focus group discussions and workshops.

e. Development of proposals for the intervention projects and according to the identified needs, for development of health education tools, training tools, group counselling handbook or guidelines, pictorial charts, and videos for facilitating discussions.

f. Conducting sensitisation campaigns to health professionals in Malawi with reminders of the importance of patient-centredness among health practitioners, for example on responding to patient resistance and offering support and empathy.

I believe that the activities proposed in this study will be possible to conduct further and implement by utilising the affordances of my position as a researcher in the field of communication studies, a lecturer in the University of Malawi who has been involved

in teaching short courses to various professionals including those in healthcare sector, and because of previous work done with organisations working in communication programmes such as USAID funded projects and Chancellor College Community Radio. Presented in the next section is a detailed discussion of the implications of the findings for practice with relevant recommendations for interventions.

8.3 Implications of the findings for HIV counselling practice

This section explicates how the data obtained in the study will be useful for the enhancement of good communication practices, through interventions that will involve several actors: engagement with the health professionals, programme developers at Ministry level, health clients, and other organisations working in the area of HIV/AIDS. The major observations and their relevant interventions are discussed in this section.

The application of the research findings has been inspired by various researchers who have undertaken projects based on the findings obtained from analysis of healthcare interactions. Just as other researchers have done, the findings can be translated into products or programmes, such as media tools and communication models (e.g. Chiu, 1993; Kreps, 2012), that will be of use at the various levels of HIV/AIDS discourse. For example, the interactional data is a valuable resource in the training of communication for health practitioners (Brown et al., 2006; Silverman, 1997); for assessment of health practitioners' practice in training centres (Sarangi, 2010a; Wodak, 1997) and as a resource for individual medical practitioners to reflect on their communicative practices (Sarangi, 2004). Another relevant example is by Peräkylä and Silverman (1991) who held workshops with counsellors using material from their conversational analysis of HIV/AIDS counselling sessions. Other researchers have demonstrated a research trajectory whereby findings of doctor-patient interaction on metaphors and description of pain (Semino, 2010) contribute to a project by involving patients, for example, by producing picture cards that patients with chronic pain used to describe the kind of pain they feel during pain-consultations which helped to empower the patients during the interaction (Semino et al., 2017) while others have used their findings to trigger debates within social policy and in media (Silverman, 1987). Emulating these researchers I suggest how the findings of this study will be applicable for health professionals to enhance good professional practice: for trainers and trainees in the training of health professionals; for policy makers towards the amendment of guidelines and style of

delivery; and for clients in order to enhance patient participation during healthcare encounters.

This study is mindful of the fact that some organisations are working with affected mothers and HIV/AIDS patients in Malawi but there is little focus on professional-client interaction, although this is said to largely affect adherence (de Kok et al., 2012). There are a significant number of programmes that are working to address the issues affecting women in relation to adherence of PMTCT recommendations, and accessing ARTs in general, *inter alia* Malawi BRIDGE II project, Dignitas International, Malawi Light House, and one that particularly follows up HIV infected mothers by creating support groups – Mother to Mother (Keehn and Karfakis, 2014). While great strides have been made to achieve the elimination of mother to child transmission, adherence is still said to be inadequate after giving birth, and a substantial number of HIV-exposed children are lost to follow-up within 24 months after birth which affects diagnosis programmes (Haas et al., 2016). Hence more attention is still required on the communication practices at the health centre and community levels. In response to this, a number of activities are planned based on the results of this study, and the sub-sections below detail the intended application plan with each action categorized to improve the HIV/AIDS discursive practices either at the micro level (section 8.3.1) or at the macro level (section 8.3.2); or at both levels together.

8.3.1 Implications of the findings at the micro level of practice

Analysing the actual healthcare practices from the interaction, and by critically discussing the participation of both the clients and the health professionals in the encounters, the study has pointed to the need for improving patient-centredness in the interaction. Having the interactional data on the communication of health provider and clients at the health centre was imperative because such data are valuable for evidence-based communication practices (Brown et al., 2006) and for reinforcement and improvement of healthcare consultations in this context and other similar contexts. Such an analysis was essential because effective health provider-client communication has been linked to patient compliance in HIV/AIDS care (de Kok et al., 2012; Penn et al., 2011; Watermeyer and Penn, 2012) and in medical interaction in general (Davis and Fallowfield, 1991). This section shows how findings of this study can be used to improve practice in the specific, local context where the data were collected and in the broader context of HIV/AIDS care in Malawi. The utilisation of the findings of this

study to the practice of counselling in healthcare in this context are outlined in this section.

a. Use of data transcripts with health professionals

Holding workshops and focus group discussions with the healthcare professionals. This will be done in order to discuss ways of improving communication in HIV/AIDS counselling. Selected data transcripts will be presented to the health professionals who were involved in this study as a way of giving feedback. Data will be shared in the form of a workshop where discussions will follow the presented data (e.g. Peräkylä and Silverman, 1991). From the methodology of looking at the micro details of the talk it is known that variations occurred within the counselling sessions in the health professionals' strategies of communication, and in turn, led to variations in clients' participation. These are nuanced distinctions within the data that were interactional and situationally dependent. By pointing out the variations occurring across the discourse strategies in the data, I will not suggest a model that will be delivered by all the health professionals in exactly the same way, but what is essential will be to encourage a critical reflection of their style of delivery.

Encouraging critical reflection is useful for enhancement of their practice and to share insights into the strengths and gaps in their communication practice in order to discuss ways of reinforcing or improving them. Critical reflection has been used in teacher education and encouraged in healthcare professions for professional development. Critical reflection is understood as "thinking about the conditions for what one is doing and the effects" (Steier, 1991: 164) at the personal, interpersonal and contextual level. It is useful in professional development to encourage professionals to critically think about their own work and how different activities and attitudes contribute to outcomes (Smith, 2011). In professional training it is encouraged as one way of improving professional practice, not just for obtaining knowledge (Barnett, 1994). Sharing data with the health professionals is one way of encouraging critical 'reflection' and fostering improved communication practice (e.g. Sarangi, 2004: 8). Sharing the subtle details of the data also leads to a reflection of the linguistic choices that the professionals make from both successful and apparently less successful interaction and the impact that they have on clients' involvement and compliance with treatment (Sarangi, 2010a).

The workshops and focus group discussions will be facilitated by focusing on the insights that health professionals will raise from the data, and based on those insights, I

will share facilitating points that are based on the major observations from the data, reflecting on the interaction by discussing any missed opportunities of involvement of the women during the sessions. Another will be to reflect on the disjunctions of knowledge, how those might affect patients' reception of care and discuss ways of incorporating them in the counselling sessions, discussing how blocking clients' contributions foregrounds information delivery rather than discussions, to encourage inclusion of not only what the patients know but also their lived experiences of what they know. These discussions will be useful to facilitate improvements towards style of delivery, topics of discussions, and areas of focus for the counselling sessions.

This data sharing session with the health professionals will be done to also gain insights that will be shared with programme developers at Ministry level. I am aware that the health professionals may not have the institutional power to change the topics and even their style of delivery completely, e.g. to move from group counselling as currently done to focus group discussions with the pregnant women, as this study would suggest. But by starting at the level of feedback and critical reflection sessions with the health professionals, insights will be gained that will feed into the recommendations at the level of policy within the Ministry of Health. The following is an example of a workshop to be held with health professionals at Khokho Health Centre as one of the intervention tools.

Workshop with health professionals at Khokho Health Centre

In this section is a detailed example of the first intervention in the form of a workshop that will be undertaken with health professionals, i.e., counsellors and nurses who work in the HIV/AIDS clinics at Khokho Health Centre. An invitation will also be extended to other health professionals from this hospital who might be interested to attend. The aim of the workshop is to share the key findings with the health professionals who participated in the study and all other health professionals who may find it relevant in order to discuss ways of improving the group counselling sessions.

Objectives of workshop:

1. To discuss the nature of interaction and types of knowledge emerging from the data.
2. To discuss strengths and weaknesses of the group counselling sessions
3. To discuss insights for the improvement of the group counselling sessions

4. To discuss insights for addressing emerging issues related to clients' everyday practices

Duration of workshop: three hours and ten minutes (including twenty-minutes break).

Estimated number of participants: Ten or more (estimated from the number of counsellors and nurses working in HIV/AIDS related programmes at Khokho health centre)

Table 8.1: Structure of the workshop

	Activity	**Duration**
1.	A briefing of the study	5 min
2.	Preamble: A. For each participant to think and jot down their ideas based on the question below (5 minutes): 1. What are your thoughts on the current achievements of the group counselling sessions? Particularly in terms of, a. the format of conducting the counselling sessions in groups b. What the various topics aim to achieve (example of topics: condom use; faithfulness; abstinence; personal risks) c. The opportunities given to clients to share their feelings and experiences about HIV/AIDS. Participants to present their thoughts with the rest of the group (20 minutes) Summary of the ideas noted and written on a flip chart (5 minutes)	30 min
3.	Activity: Discussion of aims of group counselling sessions. In relation to what was raised in discussion (2) above, we will discuss the extent to which the health professionals think some of the aims of group counselling are currently achieved and which aims may not be achieved and why. I will present a handout of extracts of the guidelines from *Handbook of Counselling* e.g. selected points from Table 4. 1	15 mins

	Ask participants to tick what they think is achieved during the sessions and what is not achieved. Rate (on a scale of 1 to 10) the extent to which they think it is achieved? e.g. a. discuss HIV prevention strategies, including: condom use, faithfulness, abstinence etc. b. discuss common risk issues and concerns c. give time for questions and clarify general issues d. defer personal issues for the 1-to-1 session Volunteers to share thoughts with the rest of the group and explain their rating.	
3.	Role -play Discussion of simplified transcripts of group counselling. One extract presented per pair a. a basic question and answer e.g. Example 4.8 b. one with active discussions, women raising concerns e.g. Example 6.3 c. with story-telling and humour e.g. Example 5.4 d. with women's input being interrupted e.g. Example 6.4 I will first guide them through the transcript, e.g. what is happening in each extract, how to read it, e.g interpreting the symbols and the participants codes. Each pair will be asked to read out and role-play their transcripts one at a time to the rest of the group . One is to read out the health professional part and the other women's part. Following the reading each pair will be asked some questions and asked to share their responses to the rest of the group as follows: **Extract 1:** To the women actors**:** Did you feel included? Did you feel that it was important to be asked those questions? To the health professionals: Do you feel convinced with the women's answers?	40 mins

	What do you feel about what the questions are achieving in the extract ? **For Extracts 2 and 4 .** To the women actors: Did you feel heard? Did you feel included? Do think you were taken seriously? To the health professionals: Do you feel you included the women in your talk? Do you think you amply attended to their views/questions? **For Extract 3**: To the women actors: Did you find the story or example helpful? Did you feel included? What elements of the explanation made it helpful? To the health professionals: What do you feel about the approach you used? I will solicit other comments to the extracts from other participants and will add their responses to the questions above. A recap of the comments. The responses recorded on a flip chart.	
	BREAK	**20 mins**
4.	Activity: Briefly presenting my study findings. The points noted from the extracts above (while bearing in mind what was raised in activity 3 above). Presenting selected feedback from the clients (interview extracts) Attending to questions or need for clarifications if any.	20 mins
5.	Activity: Group work to discuss ways of improving the group counselling sessions. In groups of four. In the groups the participants are to address the following (25 minutes): Following from the points in activity 3 and 4 above: a. Is there any need to improve the group counselling sessions?	40 mins

	b. What can be done to enhance the achievements of the sessions? Or what works and needs to be reinforced? c. In your opinion, how can issues that touch on the women's challenges or risks in everyday lives, but reflected in the group sessions, be addressed? Each group presents their ideas to the rest of the group, followed by discussions. (15 minutes)	
6.	Way forward? Brainstorming and noting the points	15 mins
7.	Closing remarks.	5 mins

The outcome of this workshop will define the nature of subsequent data sharing workshops which will be conducted at the next level with Directorate of HIV/AIDS in the Ministry of Health. The notes from the discussions held at this workshop will also be utilised during the presentations to the directorate of HIV/AIDS.

b. Use of data transcripts for amendment of counselling guidelines

Outcome of the workshop with health professionals including the relevant data will be shared with programme developers at the Ministry of Health in the form of a seminar or workshop to discuss insights for improvement. The data will be used as a basis for improvement of counselling by suggesting an amendment to group counselling and health education guidelines, and more specifically, developing a handbook for group HIV counselling that is applicable in such resource poor settings. Currently no handbook that details how group counselling sessions are handled was found. This activity is important in order to make the counselling and education sessions more interactive and client-focused than they currently are. Insights obtained from the thesis will also be shared in order to identify areas that require amendments within the group counselling and educational guidelines, with the aim of maximising the potential success of the PMTCT consultations.

It was observed that although the clients gave positive feedback to testing and counselling, which is one of the indicators of the success of the counselling, analysis of actual interaction reveals some possible deterring factors to the success of the sessions in terms of insufficient client-centredness and ignoring potential factors that could lead to inadequate adherence to recommendations of treatment (e.g. unequal gender relations and discouraging provider attitude). Hence, I suggest that there is a need to redefine communication and education in the counselling sessions of this context.

As it has been observed in the analysis of the interaction, that the women's agency as autonomous beings is rarely considered, there is an implicit focus on actions relating to treatment without adequate discussion of the challenges associated with it. Therefore, the tension between knowledge and reduced negotiation of knowledge, shows the need to amend the content of the counselling sessions. The topic of the sessions seemed basic and disregarded more substantive discussions. Accommodation of more discussions of social life of clients pertaining to HIV/AIDS treatment and management rather than focusing on health promotion as is currently the case have been found wanting and are encouraged in sub-Saharan settings, particularly Malawi (Angotti, 2012) and South Africa (Penn et al., 2011)[4].

A revision of counselling guidelines will be done by focusing on adaptation strategies in consultations with developers of the guidelines at Ministry of Health level, and more importantly based on the consultations with health professionals starting with those at the health centre where this study was conducted (as shown in activity 1 above). The counsellors and all health professionals working with the women in PMTCT clinics are an important point of contact because they are the users of and apply the guidelines in their work on the ground, compared to those who propose the guidelines (Angotti, 2012). The strategies to consider will be what sort of questions to ask, and how to approach the discussion in ways that will lead to discussion of real life experiences in addition to those that are to do with imparting medical knowledge.

c. Use of data transcripts for training

The data will also be useful for trainers at the level of training health professionals in counselling. The focus will be at the level of training of counsellors and all related health professionals in the area of HIV/AIDS. Although some scholars have questioned the excessive focus given to training in sub-Saharan Africa, in that it does not adequately prepare health professionals because there are usually contingencies in the work as they meet different people with distinctive needs (Angotti, 2010), emphasising communication strategies in training will be an important option in this context. It is

[4] In extra separate sessions "for defaulters" (as they are referred to by the health professionals and in their guidelines), two health professionals were observed as they delivered a talk to four clients (two of which were women with babies) who had skipped ART collections for two months and were required to attend special lessons for "defaulters" in accordance with the regulations of the health centre. During these sessions each of the women stated the reasons for failing to collect medication none of which were addressed directly, instead a general talk on the importance of taking medication was delivered by the health professionals in attendance.

also observed that the group health talks in general are not given adequate attention during training (see also Zulliger et al., 2014) and this was also demonstrated by some health professionals in this study who did not seem to have sufficient capacity to engage the clients in the talk. The variabilities in delivery are also noted in another study that observes that different health professionals can give rise to different ways that clients can articulate their social barriers or challenges (also Vickers et al., 2012). Thus, part of the training should aim at encouraging health professionals to have a critical reflection of their communication practices in order to think about how best to improve the nature of interaction.

Thus, the data obtained in this study will be shared with trainers of counsellors in the form of workshops because it is a useful resource for communication training and in facilitating discussions on adaptive strategies for the improvement of group counselling and educational talks. The audio data obtained in research such as this one are useful in training as well as in practice: health professionals can use the data to reflect on the effective and ineffective discursive strategies, and learn what works and what does not (Roberts et al., 2004; Sarangi, 2004), trainers can use the data to represent what is and what is not effective communication (Silverman, 1997), and for the health professionals to reflect on ways of relinquishing control over the clients as they share their concerns (Vickers et al., 2012). Actual interactional data of HIV counselling from a relevant context is useful in training than merely presenting theories of normative standards of communicative practice to trainees (Silverman, 1997).

d. Sharing findings with other health related organisations

The results will be disseminated to other organisations working in the area of HIV/AIDS and also in the local context where the study was conducted, namely Hunger Project, Dignitas International, FHI 360, Baylor International. This will be done to share insights on how best to improve the communicative practices. Working with organisations that are already working with Ministry of Health in the area of HIV/AIDS will be one approach to reach out to health professionals in different areas in the country through outreach programmes on enhancing communication practices in HIV/AIDS consultations and in all healthcare in general.

In the next section I explain my adaptation of a model of motivational interviewing (MI) which will be applied as a guide during workshops and related activities with several

actors: with the health professionals, with programme developers for the amendment of group counselling guidelines and development of the group counselling handbook at the Ministry level, and with trainers of counsellors and medical personnel towards the training of health professionals.

Motivational interviewing for HIV/AIDS education and counselling

The model of MI is applicable in the given setting and will be applied to facilitate various amendments that are proposed for improvement of professional practice. As this study suggests, guidelines should be more focused on a style of presentation that is adapted to group needs so that the counselling sessions are more accommodating of clients' participation. The current set-up for group counselling (that most antenatal clinics adopt in resource poor settings such as the current one), where some women are cautious to speak (as learned from interviews with clients), and counsellors are working against time constraints, may be a contributing factor to the limited participation of the clients and may explain the health professionals' style of resisting responses to diversions raised by clients' questions and comments. Thus the group counselling sessions will need to be modified to suit the individual needs by moving towards focus group discussions to enhance the necessary 'discussions' during group counselling sessions, and granting more private space and time for individual consultations than what is currently the case.

I will present the findings and make my recommendations for the amendment of the model of counselling to the officials in the directorate of HIV/AIDS in the form of a seminar. If permitted I will participate in the amendments programme alongside relevant officials in the directorate of HIV/AIDS. In this section I present how amendments to the current group counselling model will be done specifically by suggesting a more adaptive model of group counselling called 'motivational interviewing', which was proposed for psychotherapists by Miller (1983) and explicated by Miller and Rose (2009). This model will be suggested for trainers of health professionals and for officials in the directorate of HIV/AIDS at Ministry level as a guide to the amendment of guidelines and handbook of group counselling. MI was developed as a clinical tool for behaviour change talk and is presented as a guideline for counselling. It focuses on "responding differentially to client speech, within a generally empathic person-centered style … evoking and strengthening the client's own verbalized motivations for change" (Miller and Rose, 2009: 528).

MI emphasises a collaborative conversation whereby the clients' concerns are granted attention, and counter arguments by the clients are empathically responded to. It encompasses core communication skills, i.e., open-ended questioning, affirming, reflecting, summarising, information delivery, and advising as required in counselling. In addition to this, the developers hypothesise that the efficacy of the model is based on two factors: technical and relational. Technical factors emphasise the use of techniques, such as questions, in the promotion of change talk which hypothesises that as clients verbalise arguments for change it predicts their behaviour change. The second one – the relational factor – promotes client-provider relationship whereby empathy and acceptance by the health professional are linked to positive behaviour outcomes of clients. The relational factor is particularly relevant in this study context because the health professionals already exert an effort to relate to the clients, there is encouragement and they try to achieve client-centredness through the various strategies of collaboration. However, there is a need for consistency whereby their control over clients' needs to be reduced further by giving the client more chances to discuss issues (e.g. Vickers et al., 2012).

I therefore suggest adapting this model of counselling in the context of Malawi. The model of MI has been found to be effective in preventive medicine in Lithuania (Petrolienė, 2013) and in Sweden (Östlund et al., 2016) because it encourages the involvement of clients in reflecting on their own situation. As such, it can be applied in this resource constrained context, in which group counselling is predominantly employed in antenatal clinics, because it reinforces, *inter alia*, the strategies of collaboration, negotiation, questioning, and summarising. And indeed these are elements that are already employed by the health professionals in this group counselling and will need to be reinforced; whereas those that are less successful, such as when dealing with clients' resistance, will have to be adjusted accordingly. This model of MI has the potential to facilitate a reinforcement of the positive aspects such as evaluative and productive type of questions, reflections, and encouraging strategies that elicit comments and questions from clients which are skills that practitioners may need guidance on. These skills for MI require proper training mechanisms as they can be challenging to practitioners who exercise control, are used to directing the talk, and in some cases make predictions with reduced involvement of clients (Östlund et al., 2016) as sometimes done during the counselling sessions.

I will share the model alongside examples of interactional data with trainers for adaptation to the training of HIV counsellors, and with programme developers for the potential amendment to counselling guidelines and development of a group counselling handbook. Where permitted I will request involvement in the training. Insights from the MI model in relation to the examples from the interactional data will also be shared during workshops that I will conduct with health practitioners at the health centres. These will be done in order to discuss how best to enhance effective communication strategies in resource poor settings, such as that of Malawi and come up with an outline of strategies to impact on the guidelines at a policy level.

The next section touches on the macro contextual aspects observed in the talk and how insights of this study contribute to address them.

8.3.2 Implications of the findings at the macro level of practice

The second level of practice to be addressed is the macro level of practice. A detailed proposal of what will be done to facilitate discussions of the clients' social-cultural challenges is explicated in this section. The evidence from the study showed that there are social structures that affect the women's agency to act upon the knowledge they already have about HIV/AIDS. This means addressing issues to do with the macro structures is vital for the achievement of improved outcomes in the individual application of medical knowledge e.g. Chinkonde et al., 2009; Wodak, 1997). It was revealed from the analysis that the health centre is constructed as a site for the mere reproduction of declarative medical knowledge rather than a site that allows a truly engaged negotiation of knowledge to feed back to the social and institutional structures in ways which accommodate the material conditions of the participants. In this case explicit intervention in the social structures (macro level of discourse) of HIV/AIDS is necessary because if the macro level of discourse remains unchanged, any changes at the micro level of the discourse (i.e. during the interaction) may remain insignificant.

As shown in the analysis, there appeared to be contradictions in the discourse strategies of the health professionals which showed limitations relating to the ethos of client-centredness for the sessions on the one hand, and dilemmas in applying knowledge by the clients on the other. These contradictions and dilemmas reflected some tension between the micro and macro level discourses of HIV/AIDS. From the perspective of critical discourse analysis, the objectives of research are not only to reveal the social

inequalities but also as a "form of intervention in social practice and social relationships" (Wodak, 1997: 174). It was also noted that the structures at the macro level are not easy to change as they are sometimes implicit and may be "naturalized" – perceived as "the way things are" – hence not amenable to change (Cameron, 2001: 122). However, since the effects of the social and institutional structures on participants' practices were observed through the analysis done in this study, when sharing these findings of the study I will suggest to developers of the HIV/AIDS care programmes at Ministry level a provision of more interactive sessions between health professionals and the women.

In this section I propose a constructivist approach to health education for the improvement of the objectives of the talks that are already conducted at the health centres. The talks will be sessions that are not meant to simply 'teach' (since basic health knowledge already exists), but are for 'conscientisation' (after Freire, 1970), i.e., a promotion of 'critical consciousness' and education whereby individuals are empowered to make health related decisions according to their material and social conditions. The notion of conscientisation was developed in the context of raising consciousness among the poor in Brazil through adult literacy (Freire, 1970). Similarly, it will entail reinforcing critical health literacy whereby the women could be given more space and time to discuss the conditions of sexual practice and family life, therefore, finding ways of taking control of the circumstances of their sexual practices, for example, within the patriarchal context. This could be done through more interactive sessions that are held with individuals or families in the communities and through focus group discussions within the clinics to replace the current model of group counselling. Improvement of the model of talk will entail reinforcing individuals' health literacy from a basic one (which is demonstrated to be already in existence) to critical health literacy – "a development of their capacity for social action" (Kreps, 2012: 14).

As such, to work towards the desired social and individual change in response to the problems revealed at the macro level of discourse, the recommendations I will make to the Directorate of HIV/AIDS will be based on some of the tenets of a community health educator (CHE) model which I will briefly describe here. The CHE model is a health education model that encompasses empowerment and participation of clients at the community level by addressing existing social inequalities (Chiu, 1993). The CHE model was used in the UK around 1990s in participatory action research projects around cancer screening programmes for ethnic minorities and was useful in

empowering them to engage with health information (Chiu, 1993, 2008; Kreps, 2012). Empowerment and participation are considered important "to fully engage people in making their own choices about health as well as to recognise the need to tackle the wider social, political and economic determinants of health" (Kreps, 2012: 14).

The CHE model will be suggested to the developers of HIV/AIDS preventive programmes in the context of Malawi for the improvement of desirable outcomes in counselling and education programmes. The CHE model is applicable at the level of designing communication strategies, operational structures, development of topics and engagement of participants in order to address elements of the macro context. The model is adaptable in the context of Malawi because, just as it was applied in marginalised minority communities in the UK (Chiu, 1993), it equally addresses social structural issues and the consequential social inequalities that affect ART and PMTCT programme's client participation, especially for the marginalised participants – women – as was revealed in this study context. I will recommend to the Directorate of HIV/AIDS in the Ministry of Health to develop topics of discussions that emanate from the women or community members themselves, rather than the didactic style of pedagogy as mostly used in the current setting.

Based on my suggestions if accepted, I will join these programme developers to implement these community activities by engaging health professionals in the rural hospitals and health surveillance assistants (HSAs). HSAs already work in the communities through giving talks and administering vaccinations to under-fives. HSAs can therefore solicit clients' views on topics of concern and allow ample space and time for discussions. HSAs are in the category of community health workers and they act as intermediaries between the people and medical professionals since they live within the communities. Health workers have been found to play a pivotal role in healthcare communication in other settings, for example in South Africa where they have assisted in making global models of medicine more palatable to the local populace (Zulliger et al., 2014).

The increase in sessions held at the community level will be useful in dealing with the constraints of time that the health professionals sometimes orient to, and also be useful as part of an improvement of their communicative practices, in order to take into account the macro structures for the empowerment of the clients. Fisher (1991) suggests that health professionals are agents of social change; they can use their power to assist

patients to think of their behaviours. However, the health professionals are not the ones to speak for change but they do provide the forum where the clients can define the situations for themselves (Fisher, 1991).

In such a case, one session of counselling and education as done here, is not enough to address this change and expect the women to quickly adapt amidst their social and material conditions but there is a need to empower them into making effective decisions in three ways: 1. By making the educational sessions more interactive; 2. By increasing the sessions to include those that are held with individuals, families or small groups within the community; and 3. By developing a facilitating manual for such community engagements. These will be important because the women may need gradual and structured training to know their rights as a way of adapting to the globalised medical model that uses individual autonomy and independence in making health decisions. Thus, during the workshops with officials at the Ministry level I will propose a focus on education sessions that are informed by the issues raised at the macro level.

I will recommend to the officials to give emphasis to outreach programmes towards engaging with women and their families at the community level or those utilising healthcare in order to empower them with social skills, such as decision making and assertiveness, and through networking with business organisations they can be empowered with economic activities to boost their independence. From the insights obtained from the analysis, when accepted by the directorate of HIV/AIDS, I will develop guiding questions that HSAs can use to facilitate focus group discussions with women, families and general healthcare users as part of the intervention.

Consequently, the suggested interventions will utilise insights from this study to develop communicative channels to reach out to patients and members of public in various domains, such as charts, videos focusing on promotion of healthcare participation, and posters that target interactional strategies for healthcare users. For instance, patients waiting on benches in hospitals could be an audience for discussions by using facilitating tools such as posters, health promotional videos or charts that facilitate discussions on what sort of questions to ask, how to raise concerns and maximise their rights to access health information during healthcare. These activities will capitalise on the effective discursive strategies such as those of collaboration (as partially done in the HIV/AIDS counselling talks) and encourage individuals to take

responsibility for their health, rather than that of dependency on healthcare professionals as the authoritative voice (Dent, 2006).

These suggested activities are derived from the insights from data and will be coupled with insights from dissemination workshops with the various actors within the Ministry of Health and relevant organisations. The suggested interventions will imply utilising some of the already existing institutional structures. For instance, there is potential for the interventions proposed here because there are health workers that are already assigned in the area of HIV/AIDS – counsellors. Also HSAs already work in the communities, which is crucial as a reinforcement of these systems at health centres and that done by HSAs (community health workers) in the communities that are remote to the health centres.

More elaborate plans shall be developed according to links and collaborations that will be formed in the future following completion of this research project. This thesis has worked within a defined scope; however, it opens up more questions than could be answered within the current research and these are presented in section 8.4 as suggestions for future research in applied linguistics and social science in general.

8.4 Suggestions for future research

This research has shown the contradictions within HIV counselling sessions in Malawi. This has implications for improvement of the sessions and health communication in general, such that analysing healthcare communication is important for the improvement of provider and patient relationships, which could potentially facilitate patient compliance with the treatment. It has highlighted what contributions applied linguistics can make to the improvement of healthcare communication. While research in this context has focused on HIV/AIDS consultations only, there other consultation areas, such as malaria (which is another public health challenge in Malawi), that may benefit from a similar research, particularly in order to access communication related barriers that prevent timely access to treatment. Such research at the level of healthcare interaction is currently non-existent in Malawi. The relevance of such studies is highlighted by Montgomery et al. (2006) in the context of paediatric malaria consultations in Tanzania in which they utilised data from interviews and focus group discussions to reveal conflicts of knowledge practices between mothers and health professionals. This means that consultation practices in more areas (e.g. malaria,

diabetes etc.) of healthcare consultations in the Malawi context and sub-Saharan Africa need to be investigated in order to understand the interaction of patients and health professionals, and the interplay of knowledge systems that are essential for improved health outcomes in all areas of healthcare.

Another direction requiring an applied linguistics investigation is how the dynamics of group counselling in the antenatal settings compare with those of individual counselling sessions in general HIV consultations, and to compare the health professional and clients' communicative practices in such contexts. Analysis of the data obtained from individual counselling sessions was beyond the scope of this thesis but will be worthwhile in the future. In conclusion, although the context of the study is specific to HIV consultations in a rural hospital in Malawi the results of the study can be utilised by other healthcare practitioners in similar contexts to reflect on practice and improve communication training even for general practice and for any hospital departments where patient-health practitioner encounters occur.

I therefore, conclude this thesis by reiterating that paying attention to the different knowledge forms of the clients and patients and their effect on the discourse of healthcare is fundamental, this is not only in the discourse of HIV/AIDS but it also points to other areas of healthcare discourse in Malawian context. In the context where a large population is underprivileged and most women and children are vulnerable, according to what I observed in this study, I believe it is worthwhile to advocate for a more supportive healthcare system in terms of communication in general healthcare practice in Malawi. Thus, this thesis guides me to more future endeavors towards that effect.

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Appendices

Appendix 1: Transcript conventions

(.)	A regular pause or gap of less than a second.
(n)	Number in parenthesis indicates a pause in speakers' talk of more than a second.
::	Stretched or prolonged sounds, the length of the row of colons represents the prolongation of the sound.
(( ))	Descriptions and comments by author .
?	indicates a rising intonation
.	indicates a stopping intonation
,	indicates flat or continuing intonation
↓	indicates a falling intonation
'phrase'	indicates speaker's quoted talk
[	Indicates beginning of overlapping talk
[	indicates end of overlapping talk
WORD	Capitals for words indicate sounds that are louder than the surrounding talk.
°word°	Indicates sounds that are sofly uttered than surrounding the talk
>fast<	indicates talk that is noticeably faster than the surrounding talk
<slow>	indicates talk that is slower than the surrounding talk.
-	indicates words that are cut-off or unfinished
_____	indicates emphasis by the speaker
…	ellipses indicate omission of talk in the segment
heh or hah	indicate laughter
hh	outbreath during speech denotes laughter

Appendix 2: Consent form and information for clients

Participant identification number where applicable .....

CONSENT FORM FOR HEALTH CARE CLIENTS (INTERVIEWS)

Project Title:	The reproduction and negotiation of knowledge of HIV/AIDS in Malawi's health communication.
Name of Researcher:	Rachel Chimbwete-Phiri
(to be completed by participant)	
I confirm that I have read and understood the information sheet dated	DATE: On Information Sheet

For the above project which I may keep for my records and have had the opportunity to ask any questions I may have.

I agree to take part in the above study and am willing to *be interviewed and have my interview recorded on audio recorder.*

I understand that my information will be held and processed for the following purposes:

For academic purposes where the researcher will use it for her PhD thesis, will develop academic papers and disseminate the results at academic conferences.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason without being penalised or disadvantaged in any way.

Name of Participant	**Date**	**Signature**
Name of person taking consent if different from Researcher	**Date**	**Signature**
Researcher	**Date**	**Signature**

THE UNIVERSITY OF WARWICK

INFORMATION SHEETS FOR HEALTH CARE CLIENTS (INTERVIEWS)

Study Title: **Project: The reproduction and negotiation of knowledge of HIV/AIDS in Malawi's health communication.**

Investigator(s): **Rachel Chimbwete-Phiri**

Introduction

You are invited to take part in a research study. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take the time to read the following information carefully. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the study about?

I am in interested in better understanding how you obtain your knowledge about HIV/AIDS. And I would like to learn how your knowledge about HIV/AIDS plays a role in your interaction with health professionals and other people.

I am a student at the University of Warwick in the United Kingdom, and will use this information for my PhD studies and related publications.

Do I have to take part?

It is entirely up to you to decide. I will describe the study and go through this information sheet, which we will give you to keep. If you choose to participate, I will ask you to sign a consent form to confirm that you have agreed to take part. You will be free to withdraw at any time, even in the middle of the interview, without giving a reason and this will not affect you or your circumstances in any way. Withdrawal from the study will not affect your usual care at the health centre or any benefits to which you would otherwise be entitled.

What will happen to me if I take part?

If you are willing, I will ask you about your experiences of receiving counselling from the health professional. This interview will be audio-recorded, with your permission, and would take around 30 to 40 minutes. The interview will be held in private within the clinic premises.

What are the possible disadvantages, side effects, risks, and/or discomforts of taking part in this study?

There is a chance that talking about your experiences during the HIV/AIDS counselling may make you feel anxious or concerned during or after the interview. Feel free not to respond to any question that you do not want to, or stop me if you do not want to discuss it further.

What are the possible benefits of taking part in this study?

You may appreciate the opportunity of talking to someone about your experiences in attending HIV/AIDS care or your clinic visits.

The feedback I will give following this study may help to improve health information delivery and communication between clients and health care workers. If you wish, you will be will provided with a summary of results of the research.

Expenses and payments

There will be no payments for participating in this study. I only have a small token of appreciation to thank you for the time you will spend on this study.

What will happen when the study ends?

All the information is confidential. No one will be able to identify you from the study. Nor will we share what you tell us with health professionals or family members. Notes, audio-files and transcripts will be given a number to ensure confidentiality. Where names have to be used, we will give false names to all participants so that no one can identify you.

The audio-files from interviews will be transcribed (listened to and written down in full). The notes that I will take, the audio-files, and the transcripts will be kept safely in a locked office at the University of Warwick. It is only me, the researcher and my two academic supervisors who will be able to access this data.

At the end of the research the audio tapes and the interview transcripts will be stored in the locked office for four years.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm that you might suffer will be addressed. Any complaint about the way you have been dealt with during the study or any possible harm you might have suffered will be addressed. Please address your complaint to the person below, who is a senior University of Warwick official entirely independent of this study:

Director of Delivery Assurance
Registrar's Office
University House
University of Warwick
Coventry
CV4 8UW
Complaints@Warwick.ac.uk
024 7657 4774

If you would like any further information about the study please contact:
Rachel Chimbwete Phiri
E-mail: rcbotiphiri@gmail.com
Tel: 01789814953 UK
0888514656 Malawi.

Thank you for taking the time to read this participant information leaflet.

Appendix 3: Consent form and information for HPs

Participant identification number where applicable

CONSENT FORM FOR HEALTH CARE PROFESSIONALS

Project Title:	**The reproduction and negotiation of knowledge of HIV/AIDS in Malawi's health communication**
Name of Researcher: (to be completed by participant)	Rachel Chimbwete-Phiri
I confirm that I have read and understood the information sheet dated	DATE: On Information Sheet

For the above project which I may keep for my records and have had the opportunity to ask any questions I may have.

I agree to take part in the above study and am willing to *be interviewed, to have my counselling sessions be audio recorded, have my work activities around the health centre be observed, and have my interview recorded on audio recorder*

I understand that my information will be held and processed for the following purposes:

For academic purposes where the researcher will use it for her thesis, will develop academic papers and disseminate the results at academic conferences.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason without being penalised or disadvantaged in any way.

Name of Participant	**Date**	**Signature**
Name of person taking consent if different from Researcher	**Date**	**Signature**
Researcher	**Date**	**Signature**

THE UNIVERSITY OF WARWICK

Study Title: **The reproduction and negotiation of knowledge of HIV/AIDS in Malawi's health communication**

Investigator(s): **Rachel Chimbwete-Phiri**

Introduction

You are invited to take part in a research study. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take the time to read the following information carefully. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the study about?

This study aims to understand health information delivery and communication in health care. I would like to learn how your knowledge about HIV/AIDS is shared as you interact with clients at the health centre, or in other forums outside the health centre, or as you interact with colleagues here at the health centre.

I am a student at the University of Warwick in the United Kingdom, and will use this information for my PhD studies and related academic publications.

Do I have to take part?

It is entirely up to you to decide. I will describe the study and go through this information sheet, which we will give you to keep. If you choose to participate, I will ask you to sign a consent form to confirm that you have agreed to take part. You will be free to withdraw at any time, even in the middle of the interview, without giving a reason and this will not affect you or your circumstances in any way. Withdrawal from the study will not affect your work and position at the health centre or any other work that you do with various organisational partners.

What will happen to me if I take part?

If you are willing, I will observe the counselling sessions that you hold with clients, both on one to one and with groups. I will also ask you questions about your experiences of counselling and interacting with clients. The group counselling sessions will be video recorded while the one-to-one sessions will be audio recorded. Interviews that will be held with you will be audio-recorded, with your permission, and would take around 30 to 40 minutes.

I would also like to observe how you undertake HIV/AIDS care activities around the health centre.

What are the possible disadvantages, side effects, risks, and/or discomforts of taking part in this study?

There is a chance that being observed as you do your work may make you feel anxious or uncomfortable. Feel free to stop me from recording at any point. You are also free not to respond to any question that you do not want to, or stop me if you do not want to discuss anything further.

What are the possible benefits of taking part in this study?

The study may help improve health communication practices and health information delivery. At the end of the study I will provide you with a feedback sheet summarising the results of the study and what recommendations for improving practice are being made as a result of the research.

You may also appreciate the opportunity of talking to someone about your experiences in sharing health information or attending to HIV/AIDS clients here at the health centre.

Expenses and payments

There will be no payments for participating in this study.

What will happen when the study ends?

All the information is confidential. No one will be able to identify you from the study. Nor will we share what you tell us with your colleagues, your superiors or family members. Notes, audio-files and transcripts will be given a number to ensure confidentiality. Where names have to be used, we will give false names to all participants so that no one can identify you.

The audio-files from interviews will be transcribed (listened to and written down in full). The notes that I will take, the audio-visual files, and the transcripts will be kept safely in a locked office at the University of Warwick. It is only me, the researcher and my two academic supervisors who will be able to access this data.

At the end of the research the audio and video tapes and the interview transcripts will be stored in the locked office for four years. After four years, they will be destroyed.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm that you might suffer will be addressed. Any complaint about the way you have been dealt with during the study or any possible harm you might have suffered will be addressed. Please address your complaint to the person below, who is a senior University of Warwick official entirely independent of this study:

Director of Delivery Assurance
Registrar's Office
University House
University of Warwick
Coventry
CV4 8UW
Complaints@Warwick.ac.uk
024 7657 4774

If you would like any further information about the study please contact:
Rachel Chimbwete Phiri
E-mail: rcbotiphiri@gmail.com
Tel: 01789814953 UK
0888514656 Malawi .

Thank you for taking the time to read this participant information leaflet.

Appendix 4: Interview questions for clients

The interviews were conducted in Chichewa, the questions were translated in a local language that all could understand.

Age:

Marital status:

Level of education: Lower primary
Full primary school
Junior Secondary school
Finished secondary school
Tertiary education

(*The demographic characteristics above are important because they helped in understanding the background context of any variance that may occur between participants' responses).*

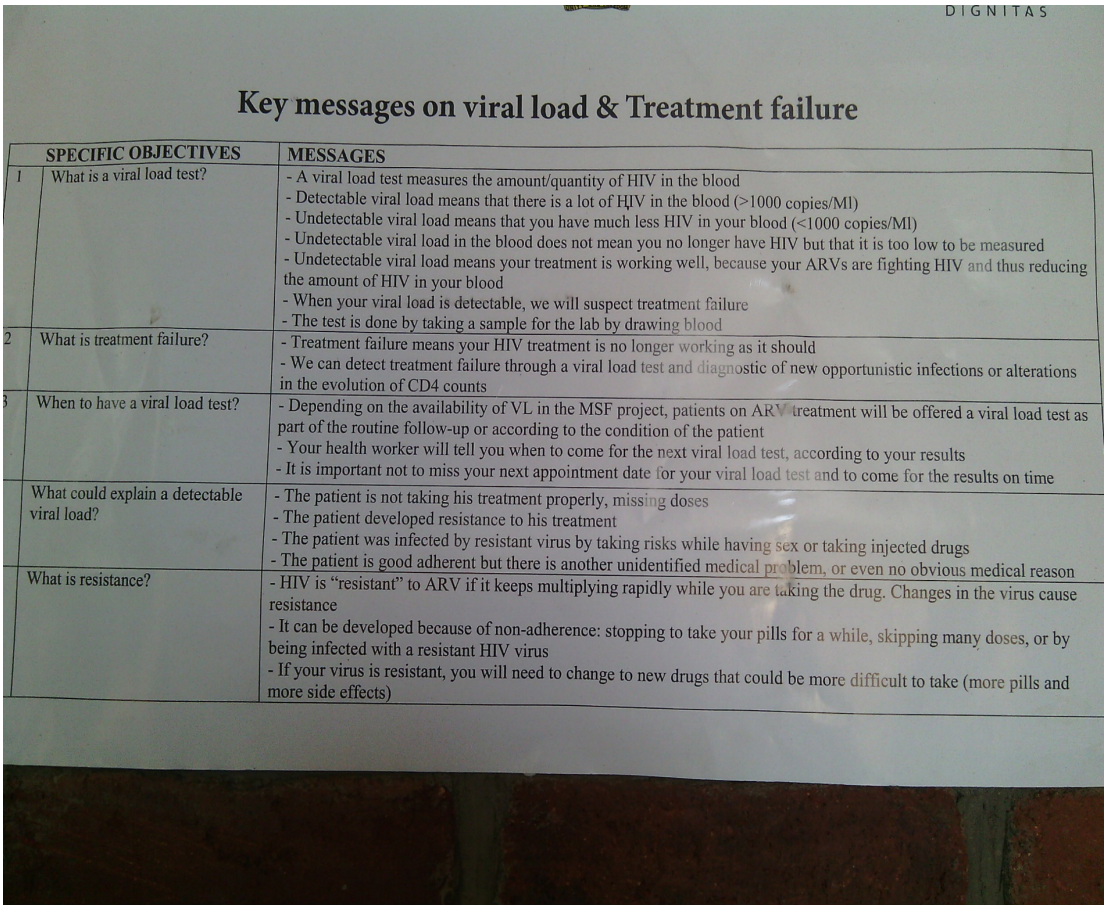
1. Have you been to a health centre or any other place for HIV/AIDS testing or counselling before today?
   1a. (If yes) how many times?
2. Can you describe your overall impression of the interaction with the counsellor/health professional today?
3. How do you feel about your participation in the interaction today?
4. Do you think that you were given ample opportunities to ask questions or respond to the information provider?
   4a. (If no) How do you think the counselling session should be improved for your satisfaction?
5. What did you know about HIV/AIDS treatment and care before your visit to the health centre?
6. Is there anything new about HIV/AIDS that you have learnt from the interaction with the health professionals today?
   6a. If so, can you explain what you have learnt?
7. Are you satisfied with the counsellors/health professionals' provision of information about HIV/AIDS treatment or management?
8. How and where do you find information about HIV/AIDS? If you want to know something about HIV/AIDS, what do you do – i.e. where do you go or who do you ask?
9. What would you consider to be the main source of HIV/AIDS information for you?
10. Do you ever get a chance to discuss HIV/AIDS issues with others, apart from the health professionals at the health centre?
    10a. If so, who else do you discuss these issues with?
11. Do you have any recommendations on how to improve the HIV/AIDS counselling?

Appendix 5: Interview questions for HPs

Type of job:
Years of experience:
Length of service at this health centre:

1. Can you describe your overall impression of the interaction with the clients during counselling or consultations?
2. What is your opinion on the nature of client participation during your interaction with them?
3. How would you describe an ideal interaction between you and the clients?
4. Is there anything that you would like your clients to do during the interaction that would make the interaction better from your perspective?
5. How would you describe the clients' level of knowledge of HIV/AIDS treatment and management?
6. Do you ever get opportunities to share information about HIV/AIDS treatment and management with clients or members of the public outside the clinic?
   6a. (If yes) Where else do you share this information?
   6b. What kind of audience do you present to?
   6c. Who else do you do these programmes with?
7. If no, do some of your colleagues have the opportunity to disseminate HIV/AIDS information outside the clinic?
8. Does this health centre have any programmes that are run for the public apart from the clinical counselling and care conducted here?
   8b. (If yes) What kind of programmes are they?
   8c. Do you have other partners with whom you run these programmes?
   8d. Who are these partners?
9. Do you have any recommendations on how to improve the HIV/AIDS counselling?

Appendix 6: Key Messages on viral load and treatment failure

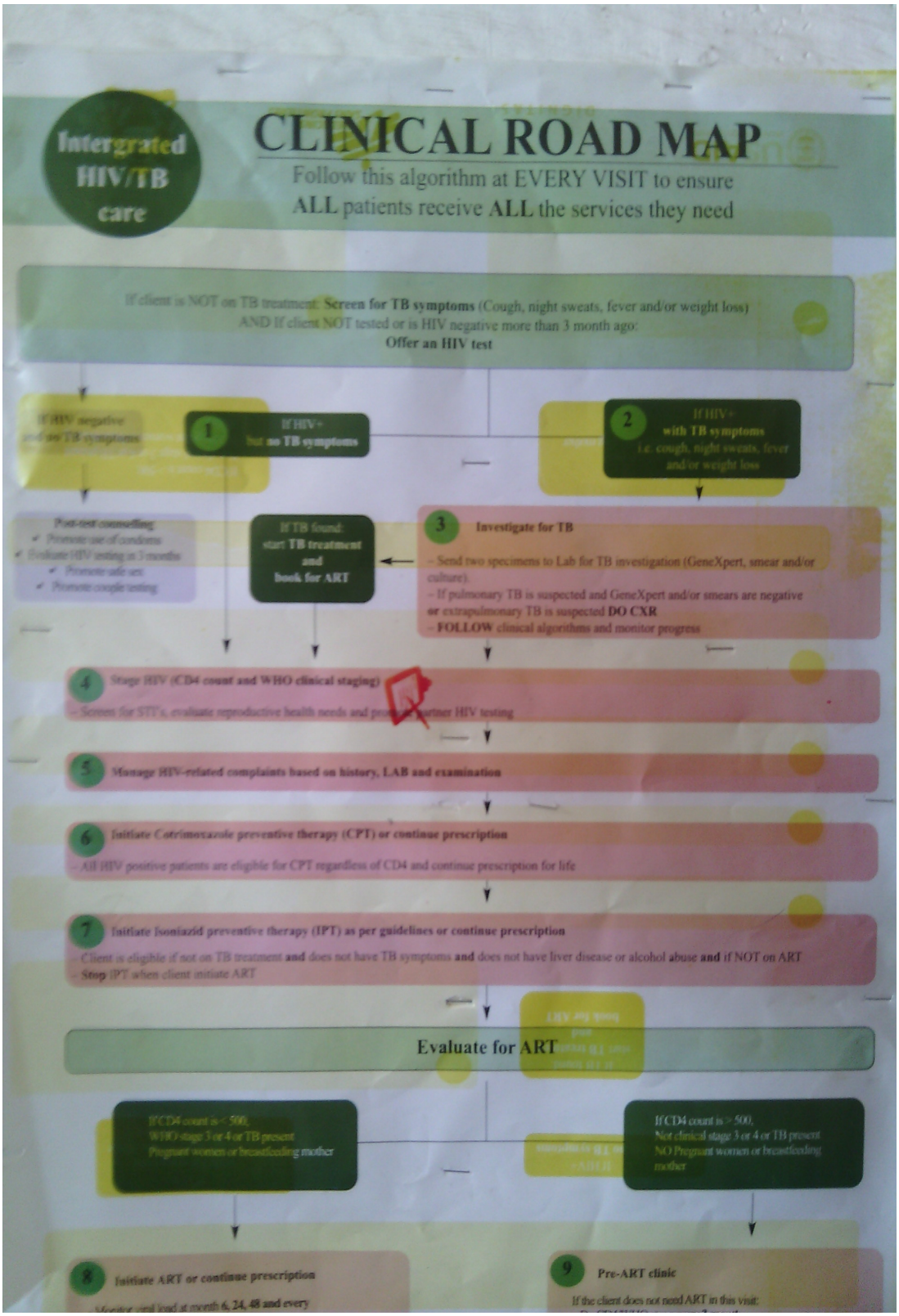


DIGNITAS

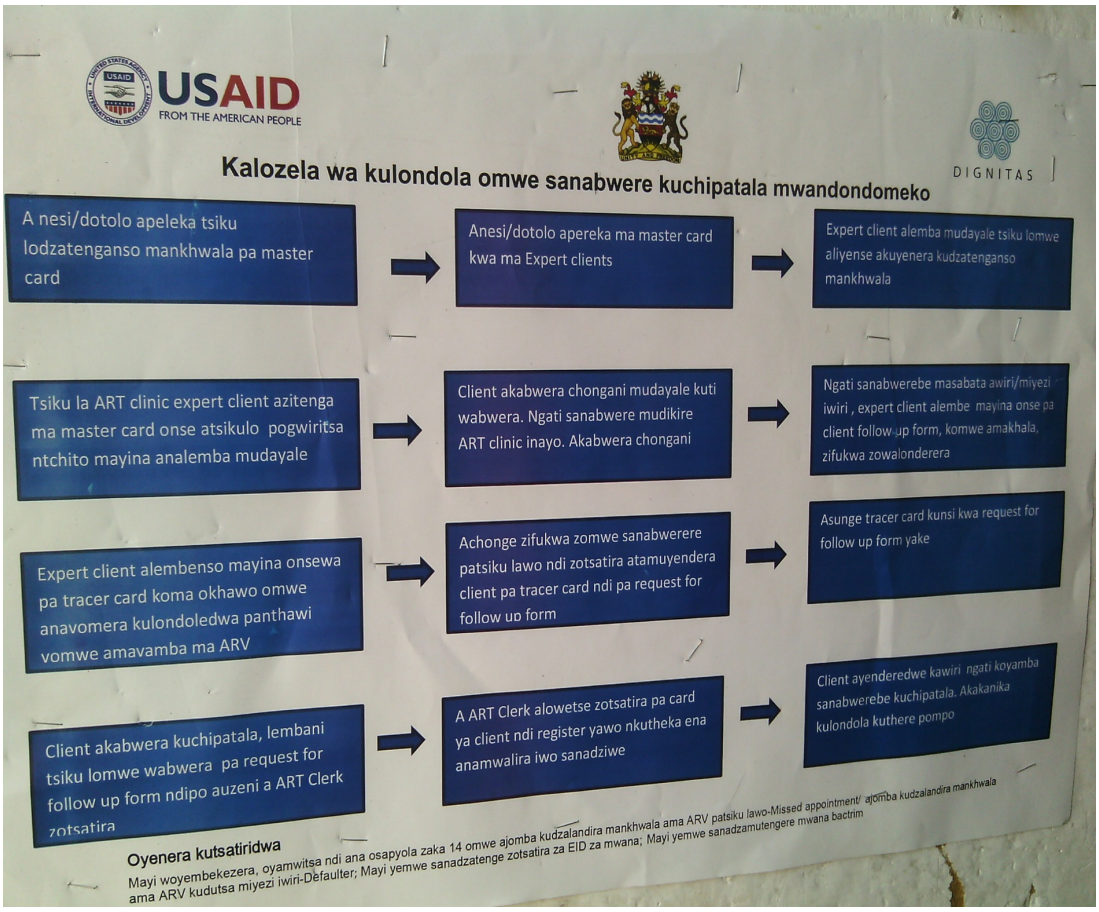
Key messages on viral load & Treatment failure

	SPECIFIC OBJECTIVES	MESSAGES
1	What is a viral load test?	- A viral load test measures the amount/quantity of HIV in the blood - Detectable viral load means that there is a lot of HIV in the blood (>1000 copies/Ml) - Undetectable viral load means that you have much less HIV in your blood (<1000 copies/Ml) - Undetectable viral load in the blood does not mean you no longer have HIV but that it is too low to be measured - Undetectable viral load means your treatment is working well, because your ARVs are fighting HIV and thus reducing the amount of HIV in your blood - When your viral load is detectable, we will suspect treatment failure - The test is done by taking a sample for the lab by drawing blood
2	What is treatment failure?	- Treatment failure means your HIV treatment is no longer working as it should - We can detect treatment failure through a viral load test and diagnostic of new opportunistic infections or alterations in the evolution of CD4 counts
3	When to have a viral load test?	- Depending on the availability of VL in the MSF project, patients on ARV treatment will be offered a viral load test as part of the routine follow-up or according to the condition of the patient - Your health worker will tell you when to come for the next viral load test, according to your results - It is important not to miss your next appointment date for your viral load test and to come for the results on time
	What could explain a detectable viral load?	- The patient is not taking his treatment properly, missing doses - The patient developed resistance to his treatment - The patient was infected by resistant virus by taking risks while having sex or taking injected drugs - The patient is good adherent but there is another unidentified medical problem, or even no obvious medical reason
	What is resistance?	- HIV is "resistant" to ARV if it keeps multiplying rapidly while you are taking the drug. Changes in the virus cause resistance - It can be developed because of non-adherence: stopping to take your pills for a while, skipping many doses, or by being infected with a resistant HIV virus - If your virus is resistant, you will need to change to new drugs that could be more difficult to take (more pills and more side effects)

Appendix 7: HIV/TB clinical road map



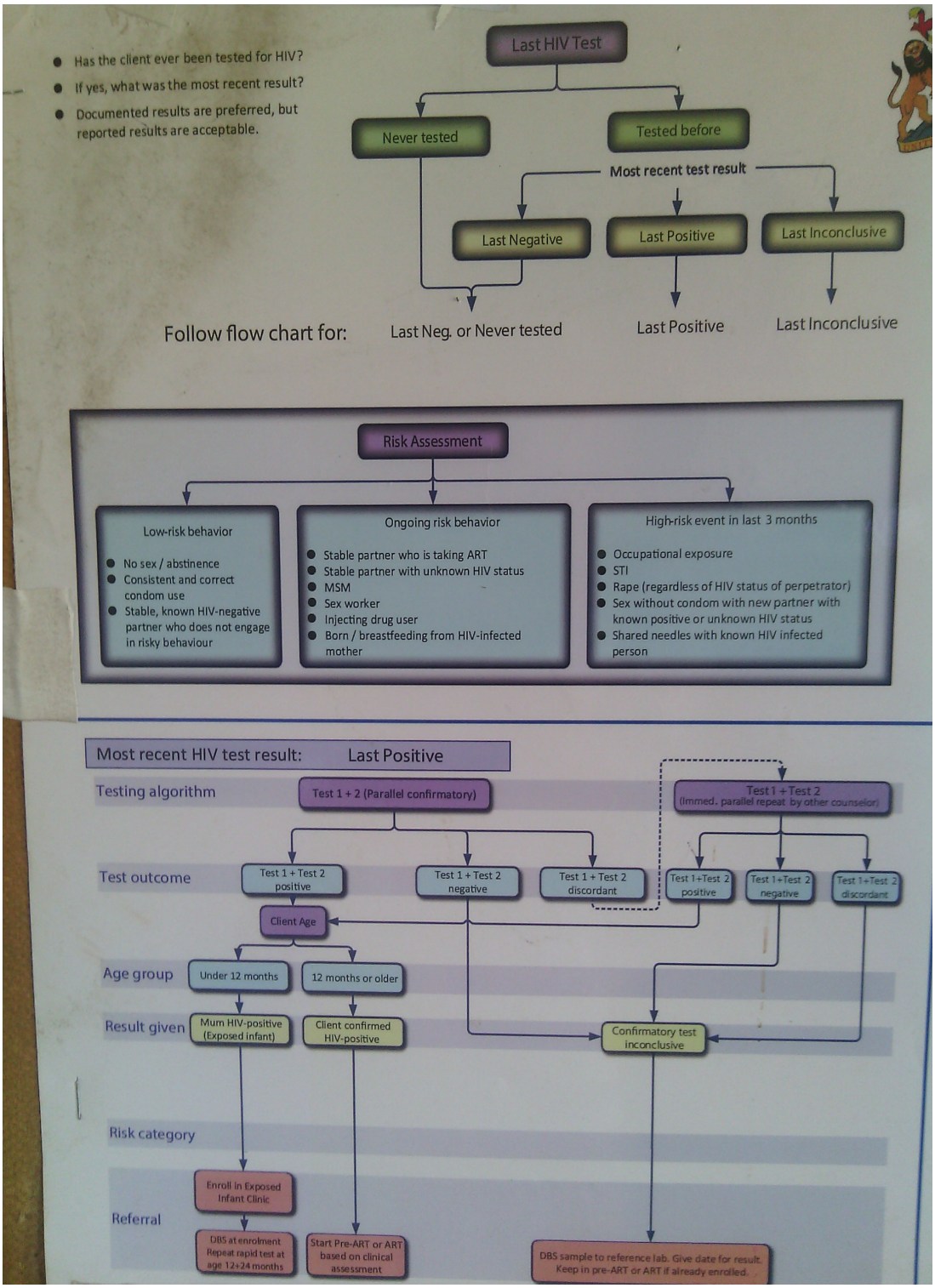
Appendix 8: Clinical road map – following non adherence



This road map is for health workers responsible for ARTclinics, it talks about what they should do during the the time clients are collecting ARVs i.e giving the client next date for collecting drugs, entering all the visits in a diary, checking the register for all attendees.

Selected sections are translated as follows: If a client misses, wait until next clinic day, if they come tick. If they miss for two weeks or two months put down their names in ‘follow-up form’. The HP should write all the names, of clients who missed, on a tracer card, include only those who gave consent to be followed up. (After following them up) HP should mark the reasons the client missed and attach the tracer card. When the client returns record the date. If the client does not return they should be followed-up up to two times, if he/she still does not return to the clinic, follow-up for them will end.

Appendix 9: Road map for PMTCT



Appendix 10: Sample of field notes

02/11/15. Monday. I am at the clinic at 7:25 am the starting time for clinics is 7:30am, so glad to be here on time. This is the day for antenatal and child clinics. OPD open as usual. About 7 pregnant women and 20 with children seated on benches in the waiting area. I join them and sit too. Concrete benches are arranged in rows. They are all facing one side where a blackboard is. Obviously outstanding, so some are staring., may be because I am writing. I greet two women near me, A few exchanges about the weather, just something to start a conversation.

Opposite this waiting area is another waiting area there are about 52 patients seated there, on benches facing two office doors, one says "Doctor's office". No health professional is in sight. More women arrived where we are seated. At 7:40 nurse and two other health workers come in (all female). They have a scale and recording books. One health worker beckons the women and they queue by the scale one by one they stand on it, and have their weight recorded in their health book and go back to sit. By now there are 19 pregnant women and 32 with babies.

08:10 am weight taking continues, those who have been weighed are back to the benches seated. Another health worker (male) comes to the area, he announces that those who are there for contraceptives should raise their hands. Three women raise their hands. He enquires if those are the only ones. Jokingly he asks: "any one who has skipped it" the women laugh. He continues, "you are laughing? I have asked is there anyone who has skipped it?". No more hands raised. He enters one of the offices. It's interesting that this could be a private matter but it is asked publicly like that.

09:20 Another health worker comes calls all the pregnant women and ask them to follow him. I followed them and all went into an HIV counselling and testing room. There are 19 women in the room. Not enough space for all to sit, so some women are seated on the floor. 09:25 Counsellor begins his talk introduces himself and introduced me. I have observed the protocols explaining and seeking consent. Happy to succeed on that. But I feel like I delay them, it takes long to explain etc but what other time can I seek consent?

The room is steaming hot. Thermometer on wall reads 35°. Last week the counsellor told me that the thermometer is an important tool for checking care and storage conditions of the test kits. The talk is on. 09:50. The women seem uncomfortable. Listening but seem exhausted. Some responding some appear withdrawn. Answering the questions when prompted though. Six of them using their health book to fan themselves. One unbuttons her blouse, has a vest inside. After sometime another takes her blouse off, remains with a vest. HP4 asks a woman sitting near the door to open it. The talks continues, somehow a challenge to the women, and to HP4, he seems to be feeling hot as well.

Appendix 11: Sample extract of interview with HPs

The interviews with health professionals (HP) were conducted in Chichewa, with some code switching to English, but only English translation is presented here due to space limitations.

Male Health Surveillance Assistant/ HTC Counsellor (HP5), 3 years' service at Khokho Health centre

R: How would you describe the clients' level of knowledge of HIV/AIDS treatment and management?

HP5: Nowadays clients, on the part of HIV, have good knowledge (.) It seems that now, messages concerning HIV have been well received (.) They have <u>really</u> received them.

R: Mmm

HP5: But sometimes there are er there are some misconceptions (.) some subtle misconceptions (.) Because when they are out there °may be° they hear people saying something somewhere (.) or when they are having conversations they share those misconceptions (.) and they take those and think that in relation to HIV, those are also part of the messages.

R: Oh

HP5: Mmh For example, some say that those who have blood group 'O' do not contract HIV . Some say that people with very hot blood compared to others do not contract HIV (.) they can have sex with an infected partner but do not contract it hah hah [hah hah]

R: [hah hah hah] okay? Hah hah

HP5: hah hah and that someone who is taking ARVs cannot transmit HIV to a sexual partner (.) People <u>in this area</u> talk about these things again and again, so we aim at <u>removing</u> such thoughts from their minds.

Appendix 12: Sample extract of interview with clients

The interviews were conducted in Chichewa, but only English translation is presented here due to space limitations. The interviews with clients were not audio recorded but in hand written notes.

Pregnant woman no. 4:
Age: 30-35
Education: up to mid primary school, year 6 (Primary ends at Year 8).

R: Can you describe your overall impression of the interaction with the counsellor/health professional today?

W4: It was okay. We were asking questions and they were explaining a number of things to us.

R: Do you think that you were given ample opportunities to ask questions or respond to the information provider?

W4: Yes. It was okay, it was just an opportunity to hear more.

….

R: What did you know about HIV/AIDS treatment and care before your visit to the health centre?

W4: I know a lot, about prevention, about care of the sick, I knew a lot.

R: What about from today's talk? Is there anything new about HIV/AIDS that you have learnt from the interaction with the health professionals today?

W4: Yes, we have still learnt something. Yes, they have told me some things that we could just hear about. So, today we have understood well.

R: specifically, what have you learnt today?

W4: a lot of, for example about HIV, prevention, protecting the baby, how we can go about it. I would say I have learnt that.

Appendix 13: Ethics approval by Malawi commission

NATIONAL COMMISSION FOR SCIENCE & TECHNOLOGY
Lingadzi House
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Ref No: NCST/RTT/2/6 **09 October 2015**

Dear Rachel Chimbwete Phiri,

RE: RESEARCH ETHICS APPROVAL OF PROTOCOL NO. P.09/15/54: THE (CO)-CONSTRUCTION OF KNOWLEDGE OF HIV/AIDS IN MALAWI'S HEALTH COMMUNICATION

Having satisfied all the ethical, scientific and regulatory requirements, procedures and guidelines for the conduct of research in the social sciences sector in Malawi, I am pleased to inform you that the above referred research study has officially been approved. You may now proceed with its implementation. Should there be any amendments to the approved protocol in the course of implementing it, you shall be required to seek approval of such amendments before implementation of the same.

This approval is valid for one year from the date of issuance of this letter. If the study goes beyond one year, an annual approval for continuation shall be required to be sought from the National Committee on Research in the Social Sciences and Humanities in a format that is available at the secretariat. Once the study is finished, you are required to furnish the Committee and the Commission with a final report of the study.

Wishing you a successful implementation of your study.

Yours Sincerely

[redacted]

Martina Chimzimu
NCRSH ADMINISTRATOR AND RESEARCH OFFICER
HEALTH, SOCIAL SCIENCES AND HUMANITIES
For: CHAIRMAN OF NCRSH

Appendix 14: Ethics approval by University of Warwick

Centre for Applied Linguistics

Application for Ethical Approval
MPhil/PhD Students

A Information

Name of student:	RACHEL CHIMBWETE-PHIRI
Date of registration:	29th SEPTEMBER, 2014
Project title:	THE (CO-) CONSTRUCTION OF KNOWLEDGE OF HIV/AIDS IN MALAWI'S HEALTH COMMUNICATION.
Supervisor:	DR STEPHANIE SCHNURR AND DR MALCOLM MACDONALD
CRB Clearance:	

B Texts

Data will be collected by observations, audio-visual recordings and interviews. The study will observe and record the discourses of group counselling and health education as well as one to one HIV/AIDS counselling in a health centre. I will also hold interviews with Malawian health professionals, health care clients and will examine institutional documents in order to understand how people perceive HIV/AIDS as a health issue and how to manage it.

Ethical approval will be sought from Graduate Progress Committee of the Centre for Applied Linguistics, University of Warwick. University of Warwick's approval his will be followed by seeking data collection and ethical approval from the University of Malawi (Chancellor College) Research Ethics Committee. It is important for the study to have an affiliation with a Malawian institution as required by the National Committee on Research in the Social Sciences and Humanities framework under National Commission for Science and Technology, a board that is responsible for granting permission and reviewing proposals for all research happening in Malawi.

Permission to conduct fieldwork at the health centre will be sought from Malawi's Ministry of health office through Zomba

1

District Health Offices and Zomba District Commissioner's office. These offices will need to be informed about the research and they are to grant permission to conduct research at the health centre within their domain.

C Participants

Details

30 health care clients to be interviewed, 15 clients from voluntary counselling and testing (VCT) centre, and another 15 from prevention of mother to child transmissions (PMTCT) clinics.

5 health professionals in the HIV/AIDS voluntary counselling and testing (VCT) clinics, and prevention of mother to child transmissions (PMTCT) clinics at the health centres. Targeted will be two nurses, two clinical officers and one pharmacist.

Clients attending group counselling or education sessions will be involved by session observations and audio-visual recordings. Audio recording will be done for one-to-one sessions while visual recording will be done for group sessions if participants agree.

Later on, data collection may involve going into the community to observe activities on HIV/AIDS by community action groups.

Respect for participants' rights and dignity

The clients will be well informed about the nature of the research, aims, and the use of their responses. All participants will have to consent to participate in the study.

Interviews will be conducted in a private room or at a private spot out of people's sight to avoid disturbances and ensure privacy.

Privacy and Confidentiality

To ensure confidentiality of responses, no participants' names will be attached to the responses, instead, numbers will be assigned to the interview recordings. Pseudonyms will be used for the transcripts and reporting of the recorded responses for the thesis and any other papers to be developed from the

collected data.

The data will be accessed only by the researcher and her two supervisors at the University of Warwick.

All participants will be offered to receive an executive summary of the findings.

D Consent

Will prior informed consent be obtained?
— from participants YES
— from others YES

Informed consent will be obtained from all study participants, and an information sheet will be presented alongside the consent form. All participants will be presented with a written consent and in cases where a participant is not able to read the researcher will read to the participant. The status of the researcher, and the use that the information will be put to will be clearly stated in the information sheet. The information sheet will explain the study in lay terms, data collection procedures undertaken by the study, protection of participant's privacy, assurance to the participants that there will not be any physical harm during the data collection process, use of the data pertaining to each group of participants, and participants will be informed of their freedom to opt out of the study at any point if they are not willing to proceed or participate.

The consent form will consist of details where participants will have to sign, or press an ink thumb (for those unable to write) if they consent to be interviewed, recorded or observed. The information and consent forms for clients at the health centre will be translated into Chichewa, a language that is understood by everyone in Zomba. The information and consent forms for health care professionals will remain in English because English, as an official language, is likely to be understood by all health care professionals. Having undergone formal schooling and training beyond school certificate level implies that a level of English proficiency is achieved.

All recruited participants (for interviews and recording of counselling sessions) will be presented with the information and consent forms, if the client does not provide consent, the researcher will move on to another client.

Consent will also be obtained from clients attending group

counselling sessions. Consent information will be presented verbally rather than in written form to all clients attending group counselling sessions. These group counselling sessions will be video recorded. Thus, before the start of a session information will be shared to all and individual consent forms will be distributed for signing. If some clients in the group are unwilling to participate the recording will not be done.

(*Consent forms and information sheets to be used in the study are attached*)

E Security and protection

Data storage

The data will be securely locked away in an office at the University of Warwick. Access to the data will be by the primary researcher and her two supervisors at the University of Warwick. No one else will use the data except the researcher. The data will be kept until the time when the researcher completes her studies at the University of Warwick.

F Protection.

The study may present some minimal psychological risks to the health centre clients who will participate in the study. Most of those who go to the clinic may be in a mentally sensitive state. In this regard, talking to people who are attending clinic on HIV/AIDS related issues will mean intruding their privacy and inviting them to speak about a potentially sensitive subject. However, some clients may actually appreciate the opportunity to talk to someone about how they feel about the HIV/AIDS care or clinic visits and may find the interview helpful in coming to terms with their feelings.

To minimise the effect of sensitivity and intrusion, the researcher will only focus on pre-test counselling sessions for general and PMTCT at antenatal clinics. This will help to avoid the post-test conversations which may turn out to be emotional for those with positive HIV status. Additionally, the researcher will try as much as possible to use courtesy and rapport strategies when approaching the clients. Hence, all interviews will be conducted by the primary researcher and not involve assistants in order not to compromise client respect.

The study presents no foreseeable risks to the researcher. It may simply be emotional to hear issues about the pandemic from people who are affected by it.

For honesty, fairness and respect of the participants, use of data from interviews will not include names and institutional information, instead the information will be reported using pseudonyms. Numbers rather than names will be attached to the interview recordings. All this will be done to avoid identifying participants.

How will you ensure that the research and the evidence resulting from it are not misused?

The data will be used by the researcher and supervisors for the sole purpose of the thesis and related articles that will emanate from it. Access to the data and use of it by any other party will not be allowed. The report will adhere to accuracy and there will not be any distortion of data obtained from the study. In some cases participants' exact words will be quoted for a true reflection of informant opinion.

G Ethical dilemmas

No ethical dilemmas anticipated.

H Authorship

Authorship of published work has not been discussed with supervisors. Authorship with supervisors will be discussed when it comes to writing a paper.

I Other issues

Incentives for study participants

A token of appreciation will be given to all clients who will be interviewed as a compensation for their time. The incentives will be given at the end of the interviews to thank them for their time. It will be important to compensate the participants for their time because the interviews will mean a delay for the participants who have just left the consultation rooms and are rushing to leave. The package will contain two packets of sugar (1kg each) and 5 tablets of laundry soap, together worth about 1,500 Malawi Kwacha, an equivalence of £2.30.

In some cases, the researcher will buy lunch or drinks for health professionals while holding conversations with them. At the end of data collection, refreshments will be organised for health care professionals at the health centre as a way of thanking them for their participation.

J Signatures

Research student **Date**

[redacted] **07/08/2015**

Supervisor **Date 8/29/15**

[redacted]

K Action

Action taken

X Approved

☐ **Approved with modification or conditions – see Notes below**

☐ **Action deferred – see Notes below**

☐ **[Where applicable] CRB clearance reported to HSSREC**

Name **Date**

Angermuller **31/08/2015**

Signature

Notes of Action

Date of Approval by Graduate Progress Committee

Appendix 15: Report of pilot study

TYPE OF DATA	No.	Remarks	Action taken
Recordings of group HTC and ART counselling sessions	1	1) Not easy to present detailed study information due to limited time at the beginning of the sessions. 2) Not easy to get everyone's consent as some clients joined the group when session and recording was in progress. 3) Limited time at the beginning of the group session posed a challenge in obtaining signatures for participants' consent.	A brief verbal presentation of study, and group verbal consent was ideal in this case. I had to pick important elements of the consent forms: the need to highlight their right to not participate in the study, asked if there was any who was not in agreement to let me know.
Recordings of one to one HTC counselling sessions	4	1) Seeking consent using paperwork was problematic. I verbally presented information about my study to the clients before giving the information study sheets for further reading, but only one client took it, the other three said they understood from what I told them and didn't need to read further. 2) After a verbal presentation of request for consent, only one client signed the consent sheet. Three clients did not want to sign. Upon further request, one said he couldn't write. I presented an inkpad for thumb stamping and he did. The other two clients refused to sign, they simply reiterated her agreement to participate.	A brief verbal presentation of the study was done at the beginning. Clients' verbal consent was considered enough because it seemed too cumbersome and unnecessary for the clients. 2) I was encouraged by the counsellors to proceed with verbal consent. Signing of documents scares people. Culturally, signing is considered as a legal binding, or used where something has legally gone wrong, therefore strange in the study situation. People mostly depend on trust such that verbal agreement is considered sufficient.
Recordings of HTC couple counselling sessions	1	Consent for participation was left to the male partner. The female partner was usually silent in the process despite an attempt to engage her; instead she simply nodded in agreement. Both partners refused to sign the consent form. The male partner assured me of their consent. The female partner was silent for a while, and after her partner's encouragement she said she had no problem in participating in the study.	Verbal consent was considered possible. I resolved to ensure that both partners are involved in the consent process.

Recordings of ARV clinics group talks	1	1) The group talks posed similar challenges in obtaining consent as those of group HTC counselling sessions above. The only difference was that there were more participants in the group talks (up to 40 participants). Recording of the speaker was not easy when they moved about the room during the presentation. It was not easy to capture audience member's questions or comments with the audio devices.	1) A brief introduction was done to all members present by standing in front of the group. Consent to record was obtained verbally from the group. Emphasis was made on their right to refuse if they do not want to get their voice recorded. 2) I resolved to continue placing the recorders in front, and take notes of all parts that were likely to be missed by the recorder. 3) I resolved to write down notes on observable points, and what I could get from the questions and comments.
Client interviews	4	The environment of the health centre in terms of time and space also had an effect on the style of interviews. 1) There was no convenient private room available near the HTC room for me to conduct interviews with clients. 2) I planned to hold in-depth interviews with the clients at the end of the session but there was limited time as they came out of the HTC room. For instance, one client was referred to ART clinic after HTC. Another female client left immediately after HTC although I booked for an interview with her. She had had a long wait for her turn into HTC room and she rushed to leave afterwards. At the end of group HIV pre-test counselling clients individually went back for testing and post-test counselling which was done hurriedly that it left little time for me to interview selected clients.	1) The only available private space was a kitchen shelter which is adjacent to HTC building. The kitchen shelter is space provided for guardians of in-patient pregnant women to cook their food. I used this shelter for interviews when there were no people cooking. When the shelter was busy I escorted clients as they left the clinic and we sat somewhere away from people within the hospital premises for a quick chat. 2) I adopted a brief conversational mode of interviewing, and reduce the questions to five major questions (refer appendix 5 on changes to the interview questions). Where possible, I asked a few key questions before pre-test counselling and left some for the end, after the counselling session. But, the interview mainly targeted the end of the counselling sessions.

		3) Two clients were audio recorded and they showed discomfort during the process, one client seemed very tensed as she responded to the questions.	3) I did not record the interview nor take notes during the conversation, rather, I recorded the conversations in a notebook after each interview. This mode of interviewing was meant to be as natural as possible and to provide a relaxing atmosphere for the client hence absence of recorder, pen and paper was considered appropriate.
Health professional interviews	1	Questions on the clients' mode of participation during interaction with health professionals were considered redundant.	Questions on clients' participation were removed from the interview schedule because it was possible to have an epistemological observation (refer appendix 2 on changes to the interview questions).
Informal conversations with 3 available personnel	N/A	There was ample time for conversations because one counsellor was responsible for HTC at a particular time. The rest of the counsellors were usually free to roam around and chat. The conversations were naturally occurring so I found taking notes inappropriate and uneasy.	I took notes at the end of conversations or whenever I got a chance to privately do so.